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INTEGRATION OF INFORMATION FOR HOSPITAL RATE SETTING

VOLUME 6: CONNECTIONS BETWEEN HOSPITAL RATE SETTING AND PLANNING IN MARYLAND AND RHODE ISLAND

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INTEGRATION OF INFORMATION FOR HOSPITAL RATE SETTING

VOLUME 6: CONNECTIONS BETWEEN HOSPITAL RATE SETTING AND PLANNING IN MARYLAND AND RHODE ISLAND

by

Drew Altman

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PREFACE

The nine states and twenty-two Blue Cross plans that engage in some form of hospital rate review or rate setting employ many different types of methodologies to accomplish their purposes. In almost every instance, however, the process for determining appropriate projected costs associated with the addition of new hospital beds, major equipment and/or new medical programs is different from the process for projecting cost increases for current, on-going services. Since a large portion of the rate increase in costs of hospital care stem from facility and program expansions, particularly those associated with high technology, rate setting efforts designed to contain such increases usually place heavy emphasis on measures to control unwarranted cost increments from these sources.

Only recently have external agencies been empowered by legislatures to influence decisions on hospital expansions - traditionally a sole prerogative of hospitals themselves. Now that states are requiring formal certification of need for new hospital projects and rate setting bodies can decide what attendant development, start-up, capital and operating costs should rightfully be included in future hospital prices, a host of new issues arise. Some of these, explored in the paper to follow, concern the relationships between planning, certificate of need and rate setting bodies as they are forced to arrive at judgments on a community's need for individual expansion projects, the impact of such projects in future hospital costs, and the extent to which such cost increments should be borne by present day purchasers of hospital care. The author deals with questions such as the locus of decision-making power and how the different bodies with legal or contractual authority for making judgments link or fail to link their activities so as to balance competing goals of patient of physician access, quality, and cost containment. The role that information plays in this process constitutes the point of focus.

The first two sections report the manner in which some of these questions are being addressed in Maryland and Rhode Island. Marked differences in approach and style are revealed. A final section draws on these two case reports for some general observations on elements in both structure and process that appear to influence and be influenced by connections between hospital planning and rate setting.

The author, a graduate student in the Department of Political Science at the Massacusetts Institute of Technology, based his study on interviews with staff members in planning and rate setting bodies, officials of hospital associations and other informed participants or observers in the states under study. Interviews were conducted during the summer of 1975. Although some subsequent events were noted, for the most part the case reports reflect the situations in Rhode Island and Maryland as of that date.

Katharine G. Bauer
June, 1976

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INTRODUCTION

This paper examines the linkages (or lack thereof) between health planning and hospital rate setting in Rhode Island and Maryland. It places special emphasis on the role that information plays as a measure of connections between organizations, asking: What kinds of data are shared? How are data shared? What are the problems that attend the information exchanges we are able to observe?

The paper is largely descriptive. It is not an evaluation of rate regulation-planning systems in Rhode Island and Maryland. Its purpose is to uncover basic problems that attend connections between regulatory and planning activities in health. Furthermore, because implementation of the National Health Planning and Resources Development Act of 1974 will significantly alter the form of planning activities in most states, the paper's description of Rhode Island in 1975 may be quite different from what begins to transpire in 1976. However, it will highlight certain common issues that may be expected to surface under the new legislation.

Today, both planning and rate setting occupy center stage spots in health policy making. In the 1960's policymakers looked to programs that called for greater equality as a palliative or even a cure for a wide range of social problems. "Equal opportunity," "equal dollars," "equal access," were the watchwords. In the courts the Fourteenth Amendment became a focus of attention. Service and income strategies vied for prominence, with the former and less threatening attracting more attention. But nothing really seemed to work. With important exceptions, compensatory input strategies failed to produce the hard and measurable outputs policymakers desired. Test scores, health indices, crime rates, drug usage rates, and, more recently, hospital costs have remained resistant to attempted social interventions. As it became clear that the desired measurable outputs did not quickly result from these programs, notions of accountablity and control displaced the rubric of the sixties.

To some, the new trend meant public accountability and control embodied in moves towards "community" boards and public disclosure. To others, the situation called for development of alternative delivery mechanisms such as HMO's. Experiments in these directions are still with us and more will be tried in the future. More often, however, accountability meant highly rationalistic, technocratic controls coupled with public disclosure. Performance standards, input-output studies, policy analysis, incentive structuring, "scientific" management employing management information systems were looked to more and more as vehicles for remedying specific social problems.

Hospital rate setting and health planning often try to embody or encourage such activities. Both are aimed at obvious and well documented failings in the health area, principally a lack of overall coordination associated with spiralling health care costs. Both are premised on an implicit faith in an ethos that says, "if we are given sufficient legal power and can get the information needed to make sound decisions, we can make significant contributions to the solution of these problems." In theory, some rough measures to evaluate the success of this proposition appear to be available to analysts and policymakers.

If health planning and hospital rate setting are central concerns of the 1970's, the notion of a linkage between the two is even more timely. It implies joining of information and authority. Strong ties between planning, rate setting and hospital bonding agencies could adjust allowable operating revenues and new capital financing to hospitals in accord with external judgments that their proposed new facilities, capital expenditures and medical programs were consistent with the articulated short and long range health needs and goals of the communities these hospitals serve. Ties between rate setters and planners, moreover, could expand the scope of planning activities to evaluate and deal with existing gaps or redundencies in hospital beds and services in relation to community need. To the extent that planning and rate setting bodies encourage consumer participation, their activities may come to represent a combination of both

technocratic (planner) and public (consumer) accountability and control. The future will determine the extent to which these two approaches, however complementary in theory, may prove antithetical in practice.

Planning and rate setting activities are performed by a wide range of public and private agencies. Organizational and political factors are, of necessity, an important part of the relations that develop between rate setting and planning agencies, and between those agencies and hospitals, third party payers, state and local governments, consumer groups, etc. Moreover, planning and rate setting agencies are themselves subject to the pressures that affect hospitals and all organizations, to expand, to enhance prestige, to protect established territory, to attract funding and political support, and a host of others. Linking planning and rate setting is much more than a purely technical activity.

If the linkages between planning and rate setting agencies are inherently political, they are also of some larger political significance. The ability of the states to develop viable and effective planning - rate-setting linkages can be expected to influence strongly both the timing and the structure of any future national health insurance program, and the federal role in health regulation in general.

The Rhode Island and Maryland cases to be described in the sections to follow were chosen for study, because at the time this study was undertaken, they represented two very different degrees of planning - rate setting agency cooperation. In Rhode Island the relationship has been symbiotic; in Maryland, it can hardly be said to have existed. The apparent differences between the two states prompt some general questions. To what extent do different organizational frameworks for conducting rate setting and health planning activities in these two states appear to produce these results? What political and bureaucratic factors are important, and of these, which can be controlled or changed? What other factors may be responsible?

In Rhode Island, hospital budgets are approved through negotiations between Blue Cross, individual hospitals, and the state Office of the Budget, depending heavily on advisories from planning agencies. In Maryland, rates are set by an independent commission that, in the past, has made its own decisions on the community need for hospital expansions; sometimes disregarding advisories from the state and individual areawide planning agencies. Because the two systems are so different, they allow a look at a wide rage of contextual factors that influence planning rate setting interaction.

At present, state rate setting and planning activities may be conducted by separate organizations or by subunits of a single organization. The movement of information between these organizations is a visible and interesting aspect of the interaction that occurs between them. Indeed, the use of planning agency data by rate setting organizations may provide a measure of the impact of the former on the latter. Many studies have observed that information often becomes an issue of political, symbolic and material significance in relations between and within organizations. From the literature, we should be sensitized to this issue in relations between planning and rate-setting organizations. However, some qualification may be necessary in the present instance. A wide range of other organizational and political factors may explain connections between the two organizations more fully, and may at least partially determine the amount and quality of the information that is shared. Reliable data and a specific state plan for setting health system goals and priorities are necessary but by no means sufficient conditions for effective planning-rate setting interaction. The special purpose of this paper will be to assess the role of information as a link between planning and rate setting in Rhode Island and Maryland, and to identify some of the specific organizational and political factors that influence this role.

SECTION I. RATE SETTING AND PLANNING IN MARYLAND

In many ways, Maryland offers a promising case for the study of state health regulation. The state's Health Services Cost Review Commission has been setting hospital rates since July, 1974, with only minimal assistance from the state's elaborate structure of planning agencies. Passed in 1968, the state's certificate of need law shares with Rhode Island the distinction of being one of the oldest in the nation. In place since 1970, the Maryland certificate of need program has had time to develop, and to demonstrate its various strengths and weaknesses. Perhaps more importantly, the organizational structure for health planning in Maryland closely resembles the structure mandated under the new health planning law, P.L. 93-641. Thus, it enables us to examine many of the organizational and political problems that may be expected to surface under the new system. Because of this, the linkages between planning and rate setting in Maryland and the failures of linkage are of special interest.

The Rate Setting Authority

The Maryland legislature established the Maryland Health Services Cost Review Commission (HSCRC) in 1971, with the strong backing of the Governor and the Maryland Hospital Association, in an effort to control the sharply rising costs of hospital care while assuring that the legitimate financial requirements of hospitals would be met. According to the law under which it functions (Annotated Code of Maryland, Article 43), it was established to:

> . . .cause public disclosure of the financial position and verified total costs of all hospitals and related institutions by means of uniform methods of accounting and to keep itself informed and concern itself with the financial viability of these institutions.

The statute provides that HSCRC was to be designed to assure that:

- Total costs are reasonably related to total services provided;

- Aggregated rates are reasonably related to aggregate costs of services;

- Rates are equitably set among all purchasers of service without undue discrimination.

In order to carry out these responsibilities, HSCRC, a seven member body appointed by the Governor, publishes guidelines, promulgates regulations and establishes rates.

The Commission's Concern with Controlling Excess Hospital Capacity

In a May 1975 position paper on selected rate regulation issues, the HSCRC highlights its concern with the problem of excess hospital capacity:

> A major factor in the inflation of hospital costs is the construction and existence of facilities that are not justified by the community's needs for such facilities and services. (Or). . . unneeded facilities or services may operate at a reasonable level of total capacity and, in so doing, may cause other nearby community facilities to be underutilized so that the net effect from the point of view of the community is the same. In either instance, the cost of excess or unreasonable capacity is paid for through increased hospital charges, insurance premiums and taxes.[1]

The statement continues, noting three probable results of having too few patients treated in a specific service:

a. Because the fixed costs of the service must be spread over a small number of patients, the cost per patient who uses the service will be higher than it would otherwise be.

b. The number of patients in a specific service may be so few that the medical and technical competence of the hospital staff in this specialty is jeopardized since they are not occupied sufficiently to maintain their skills; this can be hazardous for the patients who do use the service.

c. Other services, or cost centers, within the hospital may have to share the burden of under-utilized services, thereby increasing the average costs for all patients who use that hospital.

Finally, the statement notes that a certain latitude in the supply of hospital beds is essential to accommodate to periods of peak demand, and observes that these variations in demand can be predicted with increasing precision by statistical techniques based on the health status and age-sex composition of communities and their patterns of hospital use.

In summary, the HSCRC recognizes the central importance of adjusting the supply of facilities and services offered by the hospitals in a given geographic area to meet the needs of the population of that area--the traditional goals of hospital planning.

Many factors undoubtedly influence the extent to which the Commission seeks and uses information and advisories from Maryland's various health planning agencies in attempting to control cost excesses stemming from excess capacity. They include the Commission's basic concept of its proper role in improving the efficiency of Maryland's hospital industry, the organizational goals and state role sought by the Commission's leadership, and the availability of necessary planning expertise. However, the most important determinant of the HSCRC's links to planning agencies and, more specifically, of the extent to which its own staff conducts independent de facto planning activities as part of the rate setting process is the way in which the established planning agencies in Maryland have actually functioned.

Before reviewing the history of hospital planning in Maryland, and its present status, we will outline some of the major characteristics of Maryland's $700 million hospital industry.

The Maryland Hospitals

There are 47 general community hospitals in Maryland, all but one of which are either non-profit voluntary or state hospitals. All report their costs and budgets to the HSCRC. In many respects the industry demonstrates characteristics common to many other eastern urbanized states. For example, both occupancy and length of stay averages are noticeably higher than the

national averages. Approximately half of the acute care beds are in the Baltimore region, an area that now contains only about one fourth of the population; city hospitals are concerned that utilization of urban medical centers by non-urban residents will diminish. In the Washington metropolitan area efforts to balance urban-suburban service needs or demands through planning are complicated by the familiar and often crippling problems of overlapping jurisdictions. Between 1962 and 1973, accompanying sharp increases in the Washington suburban area population, hospital bed capacity in Prince George and Montgomery counties increased 27 percent.

In the early 1970's, the number of physicians practicing in the Baltimore area began to decline noticeably. At the same time, urban residents pressured hospitals for expansion of outpatient services. As in other cities, changing racial patterns added to tensions between predominantly white providers and predominantly non-white consumers. Thus, in the early 1970's, health planners and rate setters in Maryland were confronted with a deteriorating situation in the cities, and with considerable pressure for expansion and new construction in the suburbs.

The Background of Maryland Planning

In 1968, the Maryland state legislature had enacted a law sponsored by Senator Rosalie Abrams that implemented the federal Comprehensive Health Planning Act of 1966 by establishing the Maryland Comprehensive Health Planning Agency (MCHPA). The MCHPA was to organize the state's system federally funded areawide agencies. Subsequently, Maryland became the first state to subsidize its own area agencies. A second Abrams sponsored law was enacted in 1968 to provide for the state's certificate of need program. Certificate of need was to be administered by MCHPA, but did not take effect until 1970. In the meantime the structure and policies of the new MCHPA were being developed.

Spiro Agnew, then Governor of Maryland, was the first architect of

MCHPA. Governor Agnew named a 70 member state Advisory Council on Comprehensive Health Planning, and appointed his personal physician, Dr. Neil Solomon, as its chairman. Subsequently reduced to 36 members, the council's influence has remained largely political. Originally conceived and operated as an independent part of an interdepartmental agency, MCHPA soon became a part of the state government. In 1969, Governor Mandel combined the former departments of health and mental health to create the Department of Health and Mental Hygiene, and appointed Dr. Solomon Secretary. MCHPA became an agency in the Department, reporting directly to the Secretary, who in addition retained his chairmanship in the Advisory Council. "We are a part of the secretariate," said one MCHPA staff member, "We are, have been, and will remain a political agency, run by a Secretary with tremendous political clout." The fact that the state legislature is currently discussing the possibility of dismantling the Department, testifies to the considerable influence wielded by the Secretary under the existing arrangement.[2]

The 1967 federal Comprehensive Health Planning law (P.L. 89-749) was predicated on the belief that the states had been passive, even provider oriented in carrying out health regulation activities. One thrust of the law and, to an extent, the very early thrust of the new health planning law (P.L. 93-641) was an attempt to circumvent the state role by strengthening federal-regional planning agency ties. The CHP law did not call for specific review functions or results, but the kind of consumer and provider participation necessary to achieve its much advertised goal, a "private-public sector partnership in health." In short, it was process rather than outcome oriented.

The first executive and associate directors of MCHPA were professionals who had formerly served in the U.S. Public Health Service. "We saw as our first task the development of an environment and organization of the areawide agencies," explained the Associate Executive Director. In 1974 the executive director was dismissed, and replaced by the department's budget director. One observer explained the dismissal this way:

"Some say there was a power struggle between the executive director and the Secretary, others say there were ideological differences, and there were certainly charges of poor administration. . . . clearly a combination of all of these was involved." The MCHPA associate executive director remains, but, as of this writing, by mutual agreement no longer participates in the certificate of need reviews.

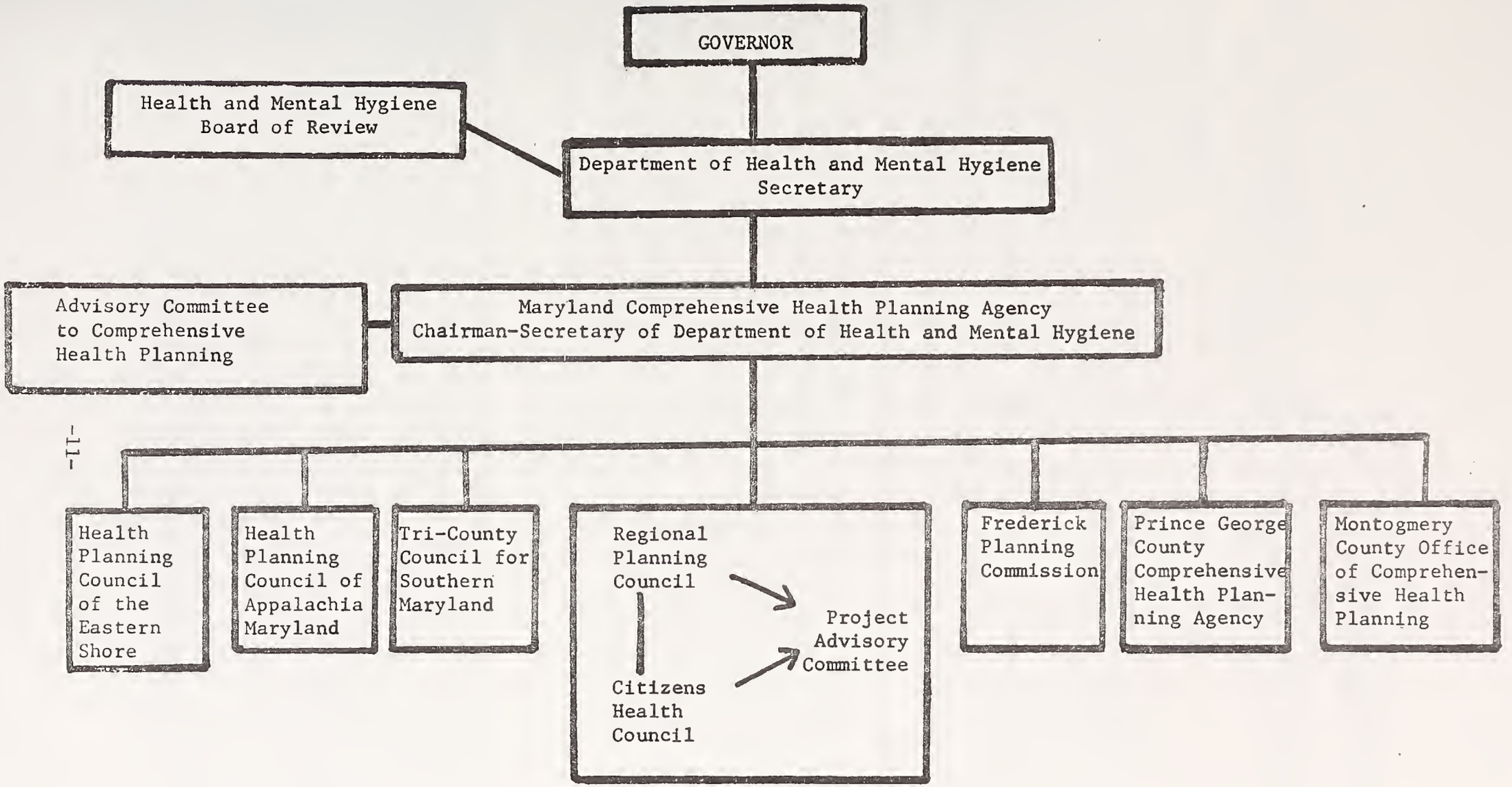
The B Agencies

While the organization of the MCHPA was largely a state matter, the areawide B agencies were creatures of the federal government. They were to be governed by representative bodies consisting of consumer majorities. Although they were to perform initial review functions in the state certificate of need programs, the B agencies were, in the beginning, to focus on developing broad community participation.

Today there are seven areawide agencies in Maryland. The largest, the Baltimore based Regional Planning Council, represents six counties and has a budget of $535,000. The health arm of the Regional Planning Council (RPC) is the Citizens Health Council (CHC). The CHC is composed of 24 delegates and 24 alternates nominated by various unions, community and civic groups selected by special Regional Planning Council panels. In addition to the Citizens Health Council, there is a Project Review Committee composed of 14 individuals chosen from, but not members of, RPC or CHC. Two other areawide agencies in Maryland maintain this same kind of two-tiered internal structure.

MCHPA, which has an operating budget of $588,000, may contribute as much as half the budget of a small areawide agency, or as little as 10 percent of a larger one. Because of this the areawide agencies have been described by the RPC Director as "quasi state agencies." Since 1974, MCHPA has assigned staff members to serve in a liaison capacity to the B agencies. The structure and the lines of authority in the Maryland Health Planning System is summarized in Chart 1.

Chart 1: Lines of Authority in the Maryland Planning Agency Structure



Certificate of Need in Maryland

MCHPA planners had not played a role in the drafting of the 1968 certificate of need legislation and did not immediately turn to the task of implementing it.[3] "All the briefings we received left it out . . . It wasn't until 1969 that we learned of its existence," one staff member has been quoted as saying.[4] Implementation difficulties were complicated by a decision delivered by the Maryland Attorney General in June of 1970, that interpreted the law so as to give MCHPA jurisdiction over expansion and relocations, not just construction. An MCHPA staff member observed: "At the time we had neither the staff or the expertise to fulfill these broad responsibilities conferred on us by the attorney general's ruling."

The regulations governing the administration of the 1968 certificate of need program were not issued until 1972. The regulations incorporated the attorney general's ruling, stipulating that the certificate of need program is to apply to all non-federal hospitals and related institutions, profit or voluntary, and all nursing homes. A certificate of need must be secured for all new hospital construction, changes in ownership, facility replacement or relocation, capital expenditures exceeding $100,000 or 2 percent of the annual operating costs during the prior year, and increases or decreases of 25 beds or 40 percent of a service, or planned change in volume of service of 25 percent or more over a two year period.

Certificate of need in Maryland is intended to include hospital programs and services. The regulations state that they cover: " . . . any new patient service to be offered, or any existing patient service to be discontinued," in the dollar or bed amounts given. "The regulations," said one Regional Planning Council staff member, "are written so as to pick up all new and expanded programs. I'm reasonably confident that applications are submitted as required by the regulations. There is in addition, a sort of grapevine that operates . . . and often we will press the hospitals in order to receive an application at the earliest possible date. In general,

I think that we have been even more liberal with program applications than construction applications." (See Appendix I for details of the certificate of conformance review process in the Baltimore area.)

The State Plan Issue

Maryland's certificate of need program is called "Certificate of Conformance to the State Comprehensive Health Plan." As defined in the regulations, the comprehensive health plan means: " . . . the overall state plan incorporating the plans for the particular areas." As of 1975, however, no such plan exists in Maryland. "Drafting the regulations themselves and setting forth criteria and goals without the aid of a real plan was a difficult procedure," remarked one MCHPA staff member.

The MCPHA Director maintains that the principal difficulty in formulating a state plan has been the failure of the areawide agencies to provide plans for the seven areas. "I hear so much about the absence of a plan. The reason there is no state plan is that we have not received area plans. The rational procedure for drafting a state plan would be to integrate the area plans, and now that is, in fact, what the new planning law (P.L. 93-641) requires."* Others argue that the absence of a true state

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* Although there is virtually universal agreement as to the absence of a viable state plan, the MCPHA has, in fact, prepared a document entitled the "Comprehensive Health Plan for the State of Maryland Health Facilities and Services." It in no way meets the criteria spelled out in the regulations. Much of the "plan" is devoted to discussion of planning goals and methodologies. Separate sections provide facilities profile data, utilization data, and population data for primary care, secondary care, and tertiary care. Although the plan is to be used as "minimum criteria in Maryland's certificate of performance program and associated section 1122 program," its substance is not geared to the review process. Its real impact upon the health care industry in Maryland is stated in the introduction: "Health care institutions should consider this health facilities and service plan as a framework for their own institutional planning, and as a guide and criteria for the preparation of their applications."[5]

plan is an indicator of a less than vigorous pursuit of health planning objectives. A Cost Review Commission staff member put the case this way: "There is no plan because they don't want a plan. The obstacles are political and economic. A meaningful plan would make flexibility and inconsistency in making reviews more difficult, and it would reinforce the rate setting process. In any event the obstacles are certainly not technical. A bright graduate student could write a plan in a week." A Maryland hospital association official expressed a different view, arguing that a plan would not be decisive. "A plan is not a substitute for communication and a sound political structure . . . when a plan is written, I doubt that it will be sufficiently specific to change things substantially."

There was in fact one major, if aborted, effort to develop a state plan in Maryland. At the urging of the Governor and the legislature, MCHPA contracted with the Johns Hopkins Multidisciplinary Health Planning group, headed by Vincente Navarro, to produce it. The resultant "Navarro Plan", as it came to be known, prescribed a uniform areawide agency planning methodology based on techniques developed in Sweden. It was interpreted as suggesting that the seven areawide agencies in Maryland be combined into three agencies, and that only university hospitals would qualify as tertiary care centers. It suggested open staff privileges at all hospitals, with admissions determined on a priority basis. Moreover, the Navarro plan called for a task force to investigate the feasibility of a "certificate of need for human services"; i.e., the licensing of doctors to practice only where a need for their services can be demonstrated. Finally, and most significantly, a single independent commission was called for that would combine both planning and rate setting functions. Due largely to these controversial provisions and to the alliance between the plan's principal author and the deposed first executive director of MCHPA, the Navarro plan became

mired in political controversy. It was never adopted.*

While many of the Maryland areawide agencies have developed some form of area plan, for the most part they are compilations of descriptive data, lacking specificity as to goals, implementation objectives, times and places. The Regional Planning Council's Areawide Plan for Health, for example, consists largely of a health facilities survey, utilization data, and rudimentary planning decision criteria. Specific recommendations are made only for bed needs in pediatric and obstetrical services. The RPC Areawide Plan for Health has been the subject of consumer criticism, much of it emphasizing its lack of specificity. Already delayed in extended public hearings, the plan must now await substantive adjustments and local organizational realignments dictated by the new federal planning law.

Confronted with an increasingly competitive application situation, and with hospital-prepared economic feasibility studies, Regional Planning Council (and other areawide agency) staff members make decisions on an individual basis. "We get applications from roughly twelve of the twenty-four hospitals in our area yearly, with half of these applying for more than one change. In reviewing each application, we must make difficult social judgments. The applications tell us what the projects look like, but the basis of our decisions really involves hospital credibility and our notion of community need," said one RPC staff member. A

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* The RPC Director's response to the plan reflected the majority view: "The Navarro plan was a lovely exercise in European style planning. . . It was not documented in terms of Maryland's problems, nor was it realistic." A Hospital Association official offered a different view: "The Navarro plan was a pipe dream, and I disagree with much of it, but it's undoing was the suggestion that a commission be established outside of the department. The plan resulted in a political confrontation between its proponents, who were associated with the dismissed first MCPHA Director and the Secretary." Surprisingly, a state health department official offered still a third view: "The plan was poorly presented. Some of the more threatening proposals, such as fewer areawide agencies, certificate of need for human services, and an independent commission were only suggestions for future consideration. Much of the real substance of the plan was viable and useful."

Health Department official was explicit: "Like most states, our planning is reactive. We respond to applications as we get them, giving early submissions an edge. For review purposes, and that is really only a part of the planning function, we only need data of the first decimal point accuracy. We make our decisions without the support of a real plan, and the hospitals are aware of it. More and more, we find ourselves having to justify our decisions in the courts."

Given the absence of a state plan and the political climate that attends health planning in Maryland in general, the maintenance of a consistent review process has been difficult. Of some 167 applications received between 1970 and 1973, MCHPA has disapproved only twelve applications totaling $35 million. "If you're measuring our effectiveness in terms of the reviews themselves," one MCHPA official stated, "it's clear that we have approved most applications." "It's not so much the proportion of approved applications that is significant, it compares with experiences in other states. But it is the history of political intervention, and more particularly, the special treatment offered the state institutions," argued a Regional Planning Council member. One official on the Maryland scene was unequivocal: "MCHPA acts as if it is in the back pocket of the industry--its performance has left a lot to be desired." However, an MCHPA official offered still a different measure of the certificate of conformance program: "It has cost only $3 million to run MCPHA, and we've turned down many more millions in construction."

The History of Planning Agency - Cost Review Commission Relationships

Meaningful connections between health planning and rate setting in Maryland have not been readily discernable. Despite some recent efforts to improve relations between the .CHPA and the Health Services Cost

Review Commission, substantial obstacles to further effective linkage and cooperation remain.

In 1971 and 1972, its first year of operation, but before it began regulating hospital rates, HSCRC participated in the planning process by conducting independent economic feasibility studies of applications for certification and provided the results to MCHPA and the areawide agencies. During that period, in a single suburban county outside of Baltimore (Howard County), three separate organizations applied for certificates of need that would allow each to construct a 200 bed hospital. The applicants were: the Hospital Corporation of America (HCA), an investor-owned chain; Bon Secours, a Catholic hospital; and Lutheran Hospital. The latter two were both well established hospitals in Baltimore. After conducting its economic analysis of the the three institutions, HSCRC ranked the applicants in the order presented above. Subsequent actions by local planning agencies and the MCHPA, however, ended in a complete reversal of the Commission's priority ordering, with the award of a certificate to Lutheran Hospital. In effect, the planners appeared to respond to political pressure and social issues rather than economic analysis, i.e., HCA was rejected because it was considered potentially unmindful of local community needs, and the Bon Secours application floundered on the issue of abortion services. Later, the one preexisting hospital in the county applied for a major expansion, and the planning question has been opened up afresh. (See Appendix II for a summary of the Howard County case.) This initial experience did not serve to sweeten planning and rate setting agency relationships. Since then, HSCRC staff has, in public hearings, questioned the cost of expansion plans in two hospitals, both with certificate of need approvals, as well as taking other actions that will be described in pages to follow.

After it began to collect its cost, volume and budget data from the hospitals on its own forms in 1974, HSCRC shared their report packages with Baltimore's Regional Planning Council, urging that they be used to supplement data gathered on certificate of performance applications.

However, such early working arrangements between planning and rate setting soon deteriorated. Baltimore's Regional Planning Council Director

explains that, from the start, there was a basic disagreement as to HSCRC's role. "We had hoped that they would act as our technical staff, sort of in a CPA capacity. But the Commission wanted to expand their role by doing their own planning, not only in assisting the reviews, but by exerting influence on planning through their control of operating budgets." An RPC health staff member added: "The hospitals had to go to great expense to process the Commission's forms. We tried to use the Commission's cost and budget data in the Howard County case, but they were too complicated, too confusing. Eventually we stopped using them altogether. We've tried to use the Commission as a technical resource, but their staffing is so limited that, often, they cannot do a timely job."

In fact, however, Cost Review Commission activities may influence the planning process itself at the area level. Prior to the Baltimore area's RPC Project Review Committee action, copies of hospital applications for certification are forwarded to other agencies, including the Commission. Communicating through informal channels, the Commission tries to exert an influence on RPC actions. "The Commission usually does not come right out and oppose our decisions. What they do is formally accept them, but let us know that they will not authorize future reimbursement for the new facility or service. In effect, they exercise a potential veto power. Often we must push for proposal modification, and have hired our own outside appraisers and hospital accounting experts in order to anticipate or counter Commission influence," said the RPC Director.

The B agencies and the MCHPA may not always be in accord in their relations with HSCRC. A staff member of one such B agency commented: "Don't confuse our attitude towards the Commission with MCHPA's. I think we are pretty much in line on philosophy, but disagree on who should do the planning."

The HSCRC has, indeed, viewed its role differently. For example, the Commission staff conducted its own estimate of the extent of excess beds in Maryland and urged MCHPA to place a moratorium on new beds at least until such time as an overall state plan could be developed. The advice was not heeded. "Our formal relationship with planning fell apart because the planners felt we were demanding too much of the hospitals,"

the Commission's Executive Director observed.

As the formal ties between planning and rate regulation, superficial as they were, became less and less effective, relations between the staffs of the Commission and MCHPA also deteriorated. "I can't tell you about the area agencies," said one Commission staff member, "but the MCHPA is a captive of the Department. They don't do their job at all, and I suspect that, should they all of a sudden be granted independent status, they wouldn't be much more effective."

De Facto Planning by HSCRC

If, as one Commission staff member put it, "planning, such as it is, has not yet impacted rate setting in Maryland except in its absence," what role does the Commission itself play? The Cost Review Commission directly involves itself in health planning by establishing certain controls on both the capital funding and the operating revenue of hospitals. Both types of controls are designed to discourage excess bed capacity in any given type of daily care service--in an individual hospital or within the geographic area served by the hospital. The goals are to control unnecessary expansion and to phase out unneeded nursing stations.

Control on capital takes two forms. First, HSCRC has replaced the traditional depreciation factor by a capital facilities allowance that its staff calculates according to a special formula for determining the need to replace any given hospital's facilities. Second, HSCRC maintains close communication with Maryland's public bonding authority, the Health and Higher Education Facilities Authority, which will not lend funds to a hospital unless the Commission indicates that it will allow the resultant interest charges as a proper element of "reasonable cost".

Existing excess capacity is discouraged by control over revenues that HSCRC will allow a hospital to obtain through its charge structure. In effect, sufficient revenues are simply not forthcoming to support an underutilized service, nor can they be transferred from other revenue

producing centers in the hospital in the form of internal subsidies, except with explicit HSCRC permission. In short, HSCRC enforces its planning activities by withholding reimbursement approval for building, capital expenditures and services it judges to be unjustified.

The Underlying Philosophy

Commission staff members take the stance that a hospital should not exercise the autonomous right to determine the community's need for its services. Traditional depreciation allowances, based on a hospital's existing plant, give the institution the power to make these decisions. HSCRC takes the position that such automatic inclusion of depreciation allowances in rates unjustifiably inflates health care costs:

> Since certain hospitals have substantial excess beds, equipment and service capacity in relation to the needs of the communities within their market areas, it is both unfair and unwise to require patients to pay for the replacement of unneeded beds or equipment.[6]

Whether or not excess capacity exists, the HSCRC Guidelines stress the principle that today's patients should pay for all costs related to the facilities which they will use. In line with this principle, HSCRC also holds that special funding, such as endowment income, where available, should be used to offset the costs of providing health services to today's patients, rather than being used to finance new or expanded facilities in the future. Capital replacements, where proven needed by the community, should be financed primarily through long-term mortgages or through the low interest tax exempt bonds of the public bonding authority. The Commission calculates the capital facility allowance to be an amount sufficient to allow for the greater of two options: cash needs to pay existing mortgages, or to provide a 20 percent down payment on necessary replacement of facilities.* Replacement value, determined by

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* In order to minimize the hospital's dependence on the short-term money market and on leasing, HSCRC does allow depreciation for equipment on a per bed basis. Both these depreciation allowances are calculated in terms of replacement costs.

consultants to the Commission on the basis of studies in a neighboring state, is currently figured at a flat $50,000 per bed. The 20 percent funding target is offset by any existing building funds the hospital may have already set aside.

Proof of need in any given case takes into consideration:

- the applicant hospital's supporting information submitted to HSCRC on special schedules designed for the purpose (part of the cost/budget report);
- formal certificate of need approvals from MCHPA; and, most importantly,
- HSCRC staff's own calculations of "target beds".

The concept of "target beds" is central to the Commission's determination of need, since the amount of any hospital's capital facility allowance is calculated solely on the target bed numbers. As will be illustrated in the excerpts from the 1975 HSCRC Guidelines to follow, target beds are established for the universe of hospitals in a particular geographic area, for each hospital service, and for each hospital. Staff members of HSCRC calculate them in terms of current utilization profiles:[7]

> Two major factors must be accounted for if utilization rates are to be viewed in proper perspective. First, one must account for the size and varieties of service in the institution. Second, the proximity of the hospital to other institutions should be considered. The basic idea underpinning this second factor is that it is reasonable to require higher utilization rates if alternative facilities are available for handling patients. In this case, any patient demand in excess of the provider's capacity might well be channeled to the neighboring facilities.
>
> Because hospitals have a variety of patient care centers in which different kinds of services are offered, hospitals will be grouped with respect to such centers. . .(for example) a hospital's obstetrical service will only be grouped, for the purpose of evaluating the utilization of this service, with the obstetrical facilities of nearly hospitals.
>
> A reasonable basis for such grouping is travel time between these institutions. More precisely, a hospital daily patient care center will be grouped with all similar hospital daily patient care centers when the hospital possessing such a center is within 15 minutes by automobile of the hospital possessing the other center.

This area target bed approach deliberately ignores the issue of physician privilege. At HSCRC one staff member put it: "Society will not bear the costs of the physician privilege system." It also ignores differences in the quality of care rendered in corresponding services of neighboring hospitals. No information is sought that might explicate such differences, or differences in patient outcomes. The Guidelines describe the factors that do enter into the HSCRC staff calculations:

> Having grouped individual hospital services as explained above, the next step will be to determine variations in the aggregate utilization of that service. From monthly variations in occupancy one can extrapolate daily variations which are the most reasonable statistics to use in estimating volume fluctuations for providers or groups of providers. More precisely, we have tentatively concluded that admissions or patient days is a Poisson variable. . . In this case a precise measure of variation in the level of service may be obtained by taking the square root of the average aggregate number of patients in the region. The guideline for establishing the appropriate number of beds for most services (e.g., pediatrics) in a given region is that obtained by adding to the average regional census in pediatrics three times the square root of that census. . .

HSCRC illustrates its methodology for arriving at both regional and institutional target beds as follows (using the example of pediatric beds):

> Hospital X is within 15 minutes of Hospitals A, B, C and D, and Hospital X has a average pediatric occupancy of 15, Hospital A of 25, Hospital B of 20, Hospital C of 21, while Hospital D has no pediatric service. The guideline for the target number of pediatric beds in the region defined by Hospital X is 108.*
>
> (15+25+20+21=81; square root = 9; 3(9)+81=108)

Having calculated the target number of pediatric beds for the geographic area in which Hospital X is located, the Guidelines then describe how HSCRC uses this number to calculate the capital facilities

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* Somewhat different formulas are used to set target beds for intensive care units, psychiatric units and coronary care units.

allowance for pediatric beds in this example hospital:

> For a particular region the total number of target beds for a given service will be allocated on a pro rata basis by utilization. . .For Hospital X discussed above, the recommended pediatric portion of Capital Facilities Allowance would be 20 beds. This derives from the following:
>
> $\frac{\text{average census of Hospital X}}{\text{average census in region}}$ times target beds; or
>
> $$\frac{15 \text{ beds}}{81 \text{ beds}} \times 108 \text{ beds} = 20$$

The switch from traditional depreciation to the capital facilities allowance has brought about substantial revenue reductions in many hospitals. Baltimore's Sinai Hospital, for example, forgoes approximately $600,000 each year that would otherwise be included in its charge structure. In early 1975, hospitals challenged the legality of the measure, and the Circuit Court of Baltimore County refused to uphold it. Later in the same year, however, at the Commission's suggestion, the legislature passed a law that clarified the Commission's right to operate under this regulation. The new law had not yet been tested at the time this paper was written.

Minimum Occupancy Rate Adjustments

Having established the number of target beds for each hospital service in order to calculate the hospitals' capital facilities allowances, HSCRC guidelines impose further controls by adjusting the charge rates for the services in accord with an assumed minimum occupancy for those services. Again, the Guidelines describe the method:

> The average regional census for the service, divided by Target Beds prescribes the minimum acceptable occupancy. In (the example) above, the minimum acceptable pediatric occupancy for Hospital X is .75 (or 81 divided by 108). . . Hospitals that budget for less than their minimum acceptable occupancy level and which in turn project high unit costs for the corresponding service will be evaluated as

> if their actual occupancy was the minimum acceptable. [Emphasis added.] More precisely, the total fixed cost of the service will be apportioned over the number of patient days that the service would realize if it were operated at the minimum acceptable occupancy. This adjusted rate will then serve as the basis for the Commission staff's recommendation.

As an example, in 1975, HSCRC disapproved $400,000 in a budget submitted for Union Memorial Hospital in Baltimore. The principal reductions related to the pediatric area where utilization was well below the prescribed occupancy minimums.

Finally, in its recommended allowance and rates, the Commission's staff will recommend applying the target bed and minimum target occupancy guidelines subject to certain maximums and minimums: for obstetrics the minimum target occupancy will never be recommended at a level greater than 80% nor less than 50%; for all other daily patient care centers, the recommended minimum will never be greater than 90% nor less than 60%.[8]

In summary, if HSCRC finds no need for continuation of a patient care center, the hospital's share of the capital facilities allowance attributable to that service is excluded. And if utilization of existing beds in a patient care center is under the prescribed minimums, the rates allowed it by the Commission will not be sufficient to support its higher unit costs. In these ways, HSCRC hopes not only to control unnecessary expansions, but also to force the hospitals to consolidate their existing services, and to stimulate referrals and joint programs.

So far, calculations of these kinds are made only for the minority of hospitals that receive individual reviews, i.e., hospitals that either request rate increases over and above the blanket inflation adjustments given by the Commission, or hospitals whose costs are found by the Commission to be out of line. Members of the Commission staff explain that their strategy is long range:

> The full effects will be seen when facility replacements are needed, and money for them is not available. . .Our objective is to fund well utilized institutions, provide

for new capacity when warranted, and force the phase-out obsolete and unneeded buildings and services.

It is apparent that HSCRC staff are deep into specific planning methodologies as they try to implement the Capital Facilities Allowance feature of their rate regulation program. In effect, the Commission has assumed the power to make determinations of need both for facility expansions and replacements and for existing programs. The concept has encountered considerable opposition from hospitals, however, and its legality is currently being tested in the courts.

A Difference of Opinion

Interestingly, while the Commission maintains that it has developed the positions and methodologies described above for such matters as the capital facilities allowance, physician privilege, and endowment dollars, and has imposed them in practice, the Maryland Hospital Association believes that these policies exist in theory more often than in fact. A Hospital Association official argued: "The Commission does use the capital facilities allowance when it takes a first look at the rates, the hospital then justifies the rates, discrepancies are identified and the two parties negotiate. Sometimes the hospitals want the capital facilities allowance, sometimes depreciation; for the Commission's part, if it can get more with depreciation, it will. More than anything else, the Commission uses the capital facilities allowance just to crank out its numbers." The Hospital Association voices a similar opinion with regards to the Commission's positions on endowment philosophy, and has substantially modified its position on the benefits of open staff privileges. "While the Commission has developed a bold philosophy and sophisticated methodologies in many of these areas, there is a wide gap between theory and practice," a Hospital Association official concluded. The Hospital Association believes that the Commission has begun to move, and will continue to move, away from its involvement in traditional planning issues and activities.

At least some of the apparent difference in interpretation and emphasis may be a product of the uncertainty that accompanies growth and change. The Commission is a new organization, and is only beginning to implement policies and procedures it has only recently developed. Both its technical practices and legal jurisdiction are being challenged in the courts. The current state of flux will not be resolved quickly. With the implementation of the National Health Planning and Resources Development Act, the stakes involved will increase substantially. The technical, organizational and political changes brought by the law will provide new occasions for bargaining and negotiation.

Controls on New or Expanded Programs

The Commission also routinely obtains information from all Maryland hospitals that could allow it to make rate decisions that would deny new funding to support new or expanded medical programs. For HSCRC budget and rate approval purposes, a new program is defined as a patient service that:

- creates a new patient service center; or
- increases the expenses of an existing center by more than 20 percent; or
- increases the fixed costs of an institution by more than 20 cents per inpatient day; or
- involves combined capital expenditure and start-up costs in excess of $20,000 or $.50 per inpatient day, whichever is smaller.

Any hospital that plans on such an expansion must complete a special schedule (W) of its annual budget report for the Commission. This schedule calls for a description of the program and an estimation of the increase in patients and units of service expected as a result of its introduction. The hospital must also report the expected effect of the program on other hospitals in the area. If the new or expanded service is already provided by other hospitals in the region, the number of patients who will be drawn away from them must be estimated in parts of the schedule

entitled "Changes in Share of Usage" and "Changes in Regional Usage." Finally, the hospital must estimate the impact of the new program on its own fixed operating costs and the units of service in its own existing service centers.

If a new medical program is added, its startup costs may not be subsidized from charges to other patient care centers, on the grounds that patients should not have to pay for services they are not personally receiving. For example, a hospital that planned to start a home care service when it applied to HSCRC for a rate, projected a volume of 1,000 visits during the first year of operation. It projected that this start up period cost would be about $80 per visit, but that this would shrink to $28 per visit when the service was in full operation. The hospital requested a temporary cross subsidy from its medical/surgical rate to close the $28/$85 gap. HSCRC's decision was to deny the request for subsidy, but to capitalize the losses in rates during the next four years. Incidentally, the Commission learned that in this case the hospital's application to MCHPA had projected 2,500 visits during the first year and a starting cost of $25 per visit. Such discrepancies in reports to the two agencies are apparently not unusual.

Reactions to the HSCRC Planning Role

In many respects, the Commission plays what one observer has labeled a "double foil role" in Maryland. First, it may act as a foil for hospital administrators, deflecting attention from themselves while assisting them to discourage or disapprove medical staff proposals which they believe to be unjustified, but which unaided they lack the power to prevent. "Right now," said a member of the Commission staff, "Hospital administrators may know very well that a proposed new program will be underutilized and uneconomic, but are not equipped to fight their doctors on the issue. In a case we are analyzing now, the medical board simply ignores the administration entirely, going straight to the trustees. In order to make our efforts work, we've got to find ways to enlist and inform hospital administrators, not crucify them." Outside observers point out that the

Commission is also a foil for MCHPA, absorbing criticism from hospitals and consumers that would otherwise be directed there. "The Commission, by virtue of its more controversial decisions, has become the focus of attention, allowing MCHPA, by virtue of contrast, to occupy a middle ground," a Maryland Hospital Association staff member observed.

HSCRC's own perception of its planning role is reflected in the following comment from a staff member:

> A certain amount of planning is implicit in the budget review process. We are confronting basic social issues all the time. We have control over operating budgets and we are prospective rather than reactive. Our regulations provide that we set rates in accordance with the State Plan, but there is no plan. The absence of a vigorous planning agency has created a vacuum we've tried to fill. The formulation of a real plan, if and when it comes, will only reinforce rather than negate our planning functions.

He went on to add: "To the extent that there have been area plans, we've used them that way."

Asked about the value judgments inherent in budget review planning decisions, this same individual commented: "Sometimes we have to make difficult social judgments, but in general, I don't find doing hospitals reviews all that difficult."*

The Commission often employs the weapon of public disclosure to gain support for its basic health policies, as well as to inform the public about inefficiencies it detects in individual hospital operations. Press releases are often issued just before public hearings are conducted

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* The Commission's position on hospital "bad debts" provides another example of social decisions. The Maryland Hospital Association, acting on behalf of many of the state's financially pressed urban hospitals, had played a major supporting role in the passage of the law establishing the Commission in 1971, largely because it believed that the Commission could be persuaded to distribute the burden of hospital "bad debts" more equitably. The Commission embraced this position, moving to require Blue Cross to pay its share of the costs the hospitals incurred providing services to the medically indigent as well as helping to make up shortfalls from Medicare and Medicaid payments.

to review an individual hospital's case. It has established a close relationship with the public bonding authority, which rarely if ever will agree to finance a new hospital project that the Commission believes is unjustified and for which it thus denies support in the rate structure for interest payments and operating costs. The Commission's Director described the power this gave him:

> Through our public disclosure powers, our subpoena powers and our control of operating budgets, we have the capacity to effectively scuttle the bond market. When one hospital, for example, came in with a proposal for a $100,000 per bed hospital, we were able to utilize this control so that the hospital is now down to about $60,000 per bed. We have used public disclosure frequently. As long as we maintain control over the bonding authority, we have ultimate control in planning.

Some observers argue that the Commission's use of public disclosure may eventually become a double-edged sword. A staff member of the Hospital Association made this case:

> If you're talking about public hearings, you're talking about consumers, not just large scale investors. Disclosure of costs may well aid the Commission, public disclosure of actions aimed at cutting those services may well hurt it. The Commission has yet to experience any consumer opposition. MCHPA has, and it is reflected in their actions. The Commission is still relatively new, and this is a delicate area.

Many observers believe that, in the future, the Commission will be increasingly constrained by a combination of consumer challenges and by the result of some of the many legal challenges. Thus far, the major Cost Review Commission controversies have involved the Capital Facilities Allowance, and procedural, "bad debts", and bonding authority issues. As the Commission continues to expand its planning perspective in setting rates, additional court challenges to its authority and practices can be expected. Hospital Association officials believe that the Commission is moving toward a less interventionist planning role and flatly predict less de facto HSCRC planning operations in the future. Here again, P.L. 93-641 may prove important. The specific planning-regulatory division of labor contained in the law may limit territorial expansion by organizations.

It spells out functional jurisdictions more clearly.

Many observers argue that the Commission must guard against an exclusive emphasis on cost factors in making what are essentially planning decisions. Often hospitals, whatever their cost structures, maintain relationships with communities that are sanctified by religious (as in the abortion issue), ethnic and racial ties. Already, charges that the Commission is not attuned to community needs have been raised.

Recent Moves Towards Better Integration

Recently, the Cost Review Commission and the MCHPA have taken steps to improve relations between the two organizations in order to more effectively relate planning and rate setting activities in the state. In part, certain very practical concerns precipitated recent cooperation. The Hospital Association, disturbed by instances in which the Commission effectively reversed MCHPA approvals through their control of the reimbursement process, and anticipating similar occurrences in the future, played a major role in bringing about the agreement. For their part, as already noted, the Commission and the MCHPA had encountered situations in which hospitals submitted different data to them for the same proposal. Although such discrepancies may sometimes have been the product of conscious manipulation, Commission and MCHPA staff members agree that more often it was a by-product of different time sequences in submission of the separate forms.

Common Application Form

The data used in the areawide agency and MCHPA reviews and for the federal section 1122 reviews will, in the future, be provided by a uniform application form for both "major" and "minor" projects. The form, designed by Ernst and Ernst and scheduled for implementation in 1976, elicits information in two categories. The financial information section includes data on construction costs, equipment costs, capital

funding sources, operating budget projections including financial projections and cash flow projections, patient mix by payment source, facility statistics and utilization by service, and a description of projection methods used by the hospital or its consultant. A section requires what it calls "cost-benefit" information. This includes an evaluation of community need, economic feasibility, alternatives, staffing goals, cost containment measures, possible non-monetary benefits, existing similar programs and services, and economic impact on the hospital should the project not be implemented.

The new arrangement calls for HSCRC, acting in an advisory capacity to MCHPA, to review all the new Certificate of Conformance applications for "major projects" (more than $3 million). Althought HSCRC has regularly received copies of certification applications in the past, as we have noted, the new arrangement is significant in that MCHPA and the Commission will now be sharing identical data for puposes of their respective review processes. Furthermore, the Commission's 1975 Annual Report stated that "interagency communication and participation in matters and functions of common interest is now HSCRC policy."[9]

The May 1975 Memorandum of Agreement

Cost Review Commission advisories under the new arrangement are still not binding in any way on the planning agencies. As stated in a May 27, 1975 memo issued jointly by the agencies (and drafted, in part, by the Maryland Hospital Association--see Appendix III), Cost Review Commission "comments will be used in addition to the CHP agencies' own reviews as an important part of the certification determination." The Commission will, in addition, comment on the updated financial feasibility statements and projections submitted to MCHPA on a "periodic basis" through the pre-licensing (first use) certification review.

In order to prevent the submission of discrepant data to MCHPA and the Commission as in the past, "the initial application submission and subsequent monitoring submissions will be preliminary rate regulation

documents as well as certification documents." Moreover, the Commission will notify MCHPA if an applicant submits data, especially financial and activity projection data, that differs substantially from that submitted to it on the annual HSCRC cost and budget schedules. In such cases, MCHPA may reconsider its certification.

As part of the arrangement, MCHPA formally accepts the planning role implicit in the rate regulation process. The joint memorandum states: "With the advent of the Health Services Cost Review Commission, financial feasibility is no longer the only relevant question. Fiscal responsibility (or reasonableness) is now of paramount importance. The solvency of a facility is not related only to what a buyer would pay, but also to what the Commission allows them to be charged - and by law the Commission must allow only reasonable costs to be recovered in rates." The memorandum, moreover, recognizes the Commission influence in the bond market. "The Commission is most anxious and willing to review plans prior to bond flotation so that a positive statement from the Commission may be included in the prospectus."

The arrangement is not without its loopholes. First, it specifies that the Commission will "report its comments in a timely fashion," a rather vague direction that may allow room for a dgree of manipulation. "Everybody knows what the time constraints on MCHPA are (these are spelled out in the state certificate of conformance program regulations), and they also know the Commission's staffing and workload limitations. Timing of applications may be decisive for hospitals, or for MCHPA if they are expecting disagreement with the Commission. The way the agreement reads, if the Commission has not been heard from by the date a decision is required from MCHPA, it will have nothing to say," argued one of the architects of the agreement. A second potential weakness is that the $3 million definition of a "major" project may allow significant changes in hospital programs and services to pass through the usual MCHPA review without Commission comments. Given the significance of the programmatic aspects of hospital costs, new programs may be expected to continue to have a sizeable if incremental impact, since joint HSCRC

and planning cooperation does not extend to the vital area of smaller program cuts and expansions. Finally, the arrangement is not a fully reciprocal one. It contains no provision for planning agency input into the Commission's rate regulation decisions.

Whatever its limitations, however, the new arrangement between MCHPA and the Commission is a first step towards the kind of cooperation that makes sense, given the present activities of the two organizations, and the objectives of existing and expected federal legislation. It is, moreover, early confirmation of the Hospital Association's prediction that the Commission will modify its early posture, and work (even prior to full implementation of P.L. 93-641) more closely with, and within, the established planning structure.

P.L. 93-641 in Maryland

Most participants in the Maryland health scene are uncertain as to the expected impact of the 1974 National Health Planning and Resources Development Act. Given the history of relations between planning and rate setting agencies detailed here, Maryland has not applied for the SSA experiments emphasizing planning and rate setting linkages funded under P.L. 93-641.* While the new planning law will influence health planning and rate regulation in Maryland in a number of ways, three appear to be most crucial.

First, Section 1533(d) mandates the development of uniform systems of cost accounting and reporting. Such unified systems may eventually replace the present uniform chart adopted in 1973 by the Commission, possibly improving the data used in Maryland health planning and rate setting, and making "special" treatment for state institutions more difficult.

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* Development funding for HSCRC was aided by funds from a Social Security Administration contract (SSA-PMB-74-237) and it is currently applying for demostration funding for methodology experimentation, and a Medicare waiver.

Secondly, the law should strengthen both planning and rate regulation functions by improving the quality of the State Plan. Health Systems Agencies are to prepare health systems plans (goals) and annual implementation plans (objectives and priorities). These are to be consolidated by the Statewide Health Coordinating Council (SHCC), with the assistance of the State Planning Agency, including the formulation of a more specific State Health Plan. However, the law in no way guarantees productive interconnection between the Plan and review process. For example, it does not mandate prioritizing of medical program applications based on the areawide or state plans. Again, although Section 1523 requires that states implement a certificate of need law, the characteristics of certificate of need review that will strengthen the Maryland process, or whether HEW will develop and publish a model law for Section 1523 specifying minimum standards remains to be seen. To the extent that the state plan is refurbished in Maryland, the HSCRC will probably strengthen its basis for asserting planning principles in setting rates.

Finally, and perhaps most significantly, the law can be expected to have some impact on the political context that is characteristic of Maryland health planning. Baltimore's Regional Planning Council is currently in the process of re-establishing itself as an independent Health Systems Agency. Decision-making at the areawide level may not longer be bifurcated, as has been the case in the past in three of Maryland's B agencies. The issue of bifurcated decision-making authority for Health Systems Agencies has been of special interest to existing regional planning bodies and county governments. While the statute itself would seem to disallow it, preliminary regulations appear to provide for considerable control over planning functions in some HSAs by these public bodies. The issue is one that ultimately will have to be resolved in bargaining during the final stages of regulations development for P.L. 93-641.

More importantly, the makeup of the Health Systems Agencies will determine the membership in the Statewide Health Coordinating Council. Through participation in SHCC, Health Systems Agencies may partially counterbalance the power exercised by the State Department of Health and

Hygiene in the past.

Generally, however, the new law would appear to strengthen the state agency in important ways. With the exception of Health Systems Agency control over some federal funds coming into their area (some with matching state funds), and HSA plans that may impact state budgets, many of the important "teeth" mandated under the law are invested in the state agency. Final authority for certificate of need, 1122 review, and the as of yet undefined "appropriateness" review rest with the new State Health Planning and Development Agency. And, as will be discussed, the structure mandated by the law would appear to strengthen state agencies in the crucial rate setting area as well.

P.L. 93-641 does not mandate the link between planning and rate setting, but like the recent agreement between MCHPA and the Cost Review Commission, it does, if political and organizational rivalries can be overcome, lay the basis for more effective cooperation, if not unification in the future.

It is conceivable, however, that P.L. 93-641 may make a meaningful planning-regulatory system impossible. This would occur if adequate funding for the expanded activities mandated under the law did not prove to be forthcoming. Unable to perform even their routine functions in a timely and satisfactory manner, planning and rate setting agencies may be hard pressed to accomplish effective combined action. Current funding estimates, moreover, seem to suggest that developments of this kind may be more a probability than a possibility at this point.

SECTION II. HEALTH PLANNING AND RATE SETTING IN RHODE ISLAND

As well as being the smallest state in the nation, with its 930,000 people distributed over 1,214 square miles, Rhode Island is the second most densely populated state. It has very little migration for health services (5 percent).[10] In comparison with national averages, the elderly are overrepresented and nonwhites are underrepresented in the state. Occupancy rates in individual hospitals range from 71 percent to 91 percent.[11] Rhode Island has fourteen short-term voluntary hospitals, three long-term state hospitals for chronic disease and mental care, and two federal hospitals.

The Background of Hospital Regulation and Planning

Health regulation in Rhode Island dates back to an 1895 act requiring the licensure of physicians and surgeons. Similar laws requiring the licensure of nursing homes and hospitals were passed in 1930 and 1932.[12]

The state's first noteworthy efforts at health planning were conducted under the auspices of the Hill-Burton Act of 1946. The Hill-Burton program emphasized distributive and allocative functions according to prescribed formulae, giving little emphasis to cost impact. Funds were allocated to most applicants, prompting subsequent allegations by Blue Cross that the program lacked meaningful planning and contributed to the costly duplication of facilities.

When P.L. 89-749, the Comprehensive Health Planning and Public Health Service Act was passed in 1966, the State Department of Health was assigned responsibility for performing certain planning functions and developing a state plan. The A agency was to identify health needs, inventory health resources, consider alternative policy directions, develop priorities, promote implementation and evaluate results. No B agency was established. As with the Hill-Burton program, Rhode Island's experience with Comprehensive Health Planning did not differ markedly from that of

other states. Lack of regulatory "teeth," influence in the political arena, provider capture, and insufficient financing, staffing, and expertise limited the program's effectiveness.

In January of 1966 the Rhode Island General Assembly called for a "commission to investigate hospital room rates and study the advisability of placing such rates under regulation." The resulting Commission chaired by state legislator Anthony Brosco, heard testimony from local and national experts for more than a year and submitted its recommendations to the legislature in April of 1967. In 1968 the state legislature adopted the Brosco Commission's most significant recommendation, establishing a Health Services Council (HSC), to include consumers, providers and payers.[13] The Council acts in an advisory capacity to the Department of Health. Seven of its members (who serve set terms) are appointed by the Governor, seven by the Speaker of the House, and five by the majority leader of the Senate.

The Council was not charged with regulating hospital rates, however, but with reviewing proposals for hospital construction for the Rhode Island Department of Health. With the subsequent writing of regulations detailing the HSC's functions, Rhode Island put in place what proved to be the nation's first hospital certificate-of-need program. Later the HSC was assigned review responsibilities under Section 1122 of the Social Security law.

In addition to the Health Services Council with its certificate-of-need responsibilities, a pre-existing voluntary areawide health planning agency, the Health Planning Council, Inc. (HPC), is another important actor in the Rhode Island scene. It had been founded in July of 1965 by a consortium of agencies to provide advisory opinions regarding hospital-related services. Thus in the late 1960s both the Health Services and Health Planning Councils were focusing their efforts on facility expansion. Since then, as we shall see later, roles and relationships between the two bodies have been shifting. These changes are manifested as they impinge on the Blue Cross Budget Review Program.

The Rhode Island Budget Review Program

In 1969, just a year after Rhode Island's Certificate-of-Need law was passed, the Hospital Association of Rhode Island (HARI) and Blue Cross of Rhode Island began a series of lengthy negotiations that eventually resulted in a voluntary prospective reimbursement program, first implemented statewide in 1971. The program was in direct response to a directive by the State Director of Business Regulation that hospitals and Blue Cross devise a mechanism to limit spiraling hospital costs. Even before the program had begun, however, the state legislature passed a law requiring that the State Director of Budget officially participate in the process and approve final hospital budget decisions. Actual participation by the Budget Office did not begin, however, until 1972.

In 1971 and 1972 all Rhode Island hospitals submitted budgets for review. In 1973 and 1974 the program was preempted by the Federal Economic Stabilization Program. In 1974 the Social Security Administration, under a Section 222 experiment waiver, joined the system for 1975 budget approvals, which then also became the basis for Medicare reimbursement as well. A representative of SSA sits in on selected budget negotiations, and in other deliberations as well. Thus the Rhode Island prospective reimbursement program embodies a unique combination of provider and major third-party cooperative activities, with its principal parties representing both private nonprofit organizations and state and federal agencies.

The system is based on individual review and negotiation of each individual hospital's proposed budget, ending in an approved bottom-line budget figure from which specific rates are subsequently calculated.[14]

The architects of the Rhode Island budget review program have always been interested in innovation. For example, as part of the 1974 experiment with the Social Security Administration, Rhode Island introduced the concept of a Maxi-Cap on total hospital expenditures for the state. Each year, well before individual hospital budgets are submitted for review, the hospital association and the budget reviewers negotiate what will be

the maximum percentage increase of total hospital expenditures allowed in Rhode Island during the coming year. Often a Social Security Administration representative sits in on the Maxi-Cap deliberations. For 1974-75 rates, for example, the statewide limit of increase was 13.85 percent, for 1975-76 rates it was 11.5 percent. Individual hospitals may get more or less than this percentage increase, depending on the outcome of their individual budget reviews, but the overall statewide limit must be maintained. Thus decisions on new facilities, new programs and routine operating budgets are made in the framework of resource allocation among competing units in an entire jurisdiction, rather than, as is the situation elsewhere, in the context of open-ended total expenditures.

The Rhode Island program offers both positive and negative financial incentives to participating hospitals. Hospitals can retain profits from costs falling below their previously budgeted figure, but must shoulder the burden of costs running over that amount. Another feature is that Rhode Island, alone among rate-setting programs so far, adjusts budget decisions to penalize excessive lengths of stay based on PAS case norms (adjusted for age and for diagnosis).*

The budget review program formally involves the two planning organizations, the Department of Health's Health Service Council and the voluntary Health Planning Council,in ways that will be described more fully in the pages to follow. In brief, the certificate-of-need and Section 1122 activities conducted by the Department of Health and the Health Services Council influence the budget negotiations only in the most obvious way. The budget reviewers simply do not reimburse for interest and depreciation where capital expenditures requiring certification have not been approved. The more unusual relationship is between the Health Planning Council and the budget reviewers. Here, as we will see, before a hospital is allowed an immediate increase in either its operating or capital budget to support a new or expanded medical program involving expenditures above a prescribed

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* PAS is the acronym of the Professional Activity Study of the Commission on Professional and Hospital Activities, Ann Arbor, Michigan.

magnitude, that program must have received a top-priority rating from the Health Planning Council in terms of community need, together with a favorably written advisory opinion stating how the program fits into the overall goals and objectives of the Rhode Island health system.

Information to Inform Budget Reviews

Before describing this new program review process in further detail it may be helpful to present a summary, in Chart 2, of the various sources and flows of data and reports that inform the parties to the process. The reader will note that the hospital provides various types of basic data about its operations to several different organizations that process and analyze it. Other types of data necessary for health-service planning are received from other sources, such as the U.S. Census, household surveys, etc. Rhode Island has the good fortune to have an unusually well developed health information system capability, Rhode Island Services Research, Inc. (SEARCH), that stores and analyzes much of the data required for hospital planning, and thus through the arrangements described above, for budget approvals.*

As Chart 2 shows, the Budget Review Committee does not collect or receive planning data directly, but depends on the analysis and advisories it receives from HSC and HPC for its decision making on capital and program expansions.

The next section will describe the nature of the two planning organizations, HSC and HPC, to provide a better background to their relations with the Budget Review Committee.

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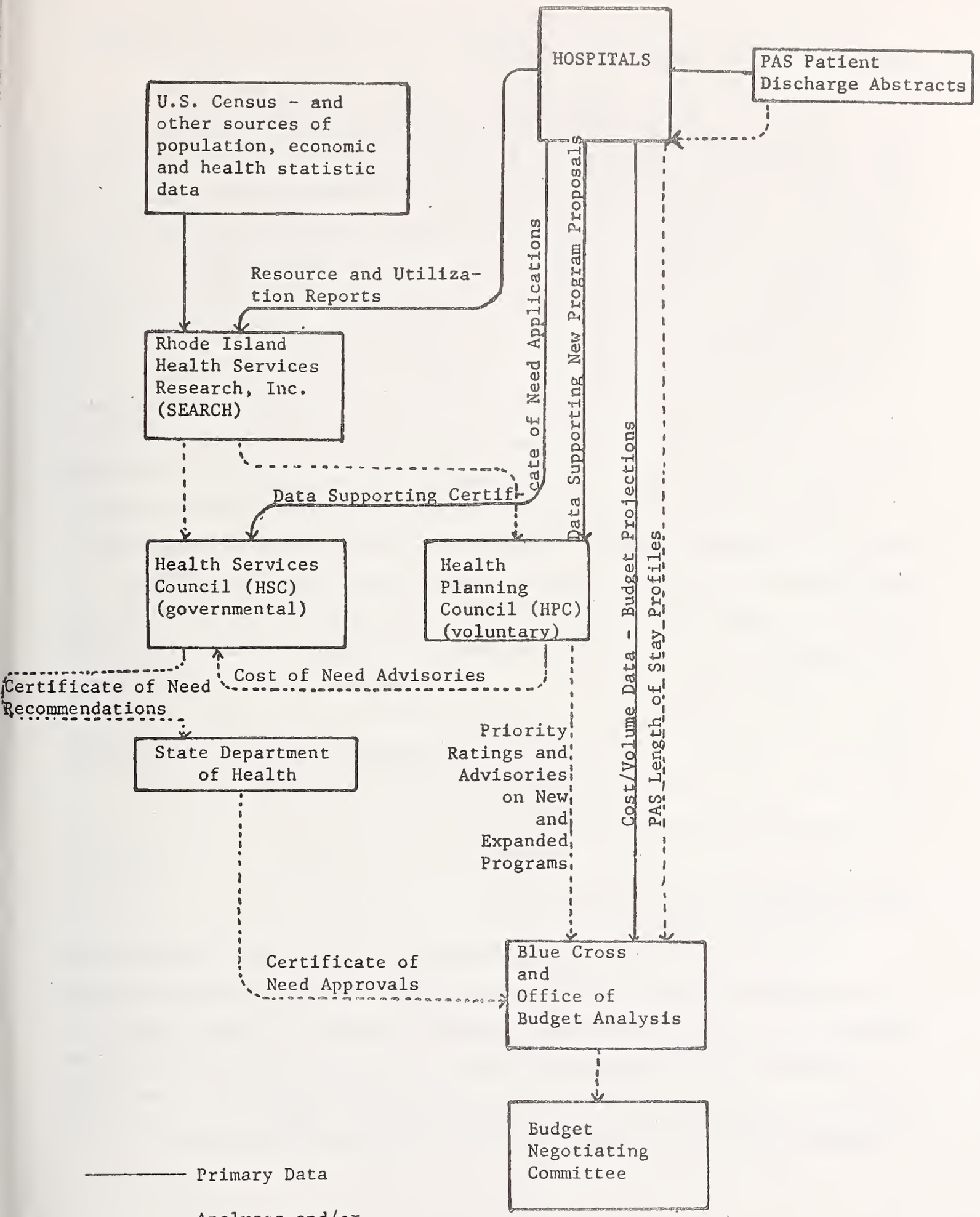
* SEARCH also receives patient medical record abstracts from the Professional Activity Study (PAS). However, the Budget Review Committee, as a measure of economy, obtains its PAS reports directly from the hospitals.

Chart 2. Types of Information used in Rhode Island Budget Negotiations: Sources and Flows



The Role of the Health Services Council

As we have seen, the Health Services Council (HSC), composed of political appointees, conducts the certificate-of-need reviews in Rhode Island and acts in an advisory capacity to the Director in the Department of Health. It has also been conducting Section 1122 capital expenditure reviews for the federal government as part of its regular operation. However, because the Secretary of HEW, through the Regional Office, has not agreed to the State Department's method of conducting capital expenditure reviews, Rhode Island did not sign a formal Section 1122 contract.

HSC's certificate-of-need reviews are guided by two state health plans: one developed by the Department of Health, and the other by the Department of Mental Health. The Department of Health draws up annual short- and long-range plans and a health-care facilities plan that summarizes the bed and manpower needs of the state as a whole. The Department of Mental Health plan stresses current needs for mental health services. HSC reviews are also assisted by advisories from the voluntary Health Planning Council. In this respect, as many observers have indicated, HPC in fact performs staff functions for the Department. This arrangement, which has been in effect since 1970, was formally noted in 1974 when the Department of Health, the Health Services Council, Blue Cross, HARI and HPC issued a joint policy statement officially recognizing HPC as the "other planning agency" in the state.

The Health Planning Council's Role

The Health Planning Council (HPC) has always worked with a variety of health agencies besides furnishing its advisories to the State Department of Health. In 1967, for example, Blue Cross ammended its 1966 contract to provide that Blue Cross and the hospitals "shall act in conformity with and abide by the planning criteria as established by the Planning Council." In general, HPC has been aggressive and purposeful, although of course its

advisories in no instance carry the force of the law.

The members of the Health Planning Council are not representative of the community at large. Instead, membership consists almost exclusively of bankers, judges, attorneys, physicians, businessmen and educators, reflecting the distribution of political and economic power in the community (and on hospital boards.) The Council has long been active in planning for health facilities and services. Even in its first years of operation, HPC worked to prevent the establishment of a second osteopathic hospital, to settle disputes between medical staffs, promoted the development of hospital long-range planning committees, reduced proposals for medical/surgical bed additions, and undertook extensive studies of hospital service areas and proposals for open medical staff appointments. A Health Planning Council report issued in 1969 recommended the extension by hospitals of temporary privileges to non-staff physicians and the limitation and coordination of open-heart surgery services. Another HPC report argued for consolidation of obstetric services at the Providence Lying-in Hospital, and for phasing out of obstetric services in three area hospitals. In 1972 the HPC began to supply advisories to the Blue Cross - Office of Budget review staff.

Medical Program Review Linked to Rate Setting

Although HPC had pressed since 1966 for greater involvement in the planning process, the impetus for HPC's medical program reviews came from the Blue Cross budget program. In the first year of the program, 1971, a year marked by cutbacks in private industry and mounting unemployment in Rhode Island's cities and towns, Blue Cross was faced with hospital proposals for new and expanded programs totalling some $5.3 millions. Blue Cross argued forcefully that the proposed increases were unacceptable but that it was in no position to reduce the total through the regular processes of budget negotiations.

Further, and most important, in the absence of a specific state

plan or a formalized procedure for judging proposals for new or expanded medically oriented programs and services, Blue Cross found itself in the somewhat untenable position of having to make de facto planning decisions in its budget negotiations with individual hospitals. In a memo dated August 27, 1971, Blue Cross stated its problem clearly:

> Blue Cross is not qualified to make essentially medical and social judgments as to the desirability of new or expanded programs at any individual hospital. Even if the plan were qualified in this area, we would be reluctant to attempt to impose our judgment on that of the hospital staff and its Board of Trustees.

The President of Blue Cross wrote:

> Since we do not feel qualified to make medical and social judgments as to the need for new programs, we do not wish to be in a position of agreeing to a budget including substantial expansion at one hospital and arguing against it at another. We believe the public is far better served if the hospitals collectively discuss with Blue Cross a publicly credible mechanism for establishing priorities among those programs being prepared.

The discussion of these matters called for by Blue Cross was conducted by the established Hospital Association-Blue Cross Liaison Committee. The work of hammering out a review mechanism was given to a specifically appointed subcommitee.

In November of 1971 the Subcommittee to the Liaison Committee agreed to enlist the services of the Health Planning Council in making medical program decisions and to increase its funding accordingly. The list of prospective candidates for the job was sizeable, but HPC's claim to it was a solid one. Although largely a one-person staff operation since its inception HPC has always been prolific and aggressive, establishing the credibility necessary in the absence of specific legal authority for program reviews. In addition, HPC was not formally tied to the political arena, as was the Health Services Council of the Department of Health. HPC was independent, but, given the make-up of its Executive

Committee, it did not seem to be impenetrable: communication and bargaining were entirely possible, indeed, welcome. Close personal ties between a Blue Cross Vice President and HPC's Executive Director strengthened HPC's candidacy and reinforced subsequent relationships between the two organizations.

Initially, the hospitals accepted the concept of a new planning role, but demurred at the proposed process. In the hospitals' view, HPC was to engage in a "new positive planning role" -- to formulate goals and to provide direction and coordination. It was to modify its past role of "reactive planning," limited to considering hospital proposals, usually for major facilities construction, and issuing endorsement or disapproval advisories. Now, in addition, HPC was to inventory hospital services and provide long- and short-range plans for such services, suggest "general" long- and short-range goals for "consideration" by the hospital industry, and update its statement of goals prior to March 31st annually.

Thus, the hospitals initially interpreted Blue Cross-HPC intentions rather loosely, emphasizing broad planning functions exclusively. A December 3, 1971 Liaison Committee memo put it this way:

> . . .in addition to the existing processes of franchising and budgeting negotiation, there should be an additional role to be filled by a community-based, qualified health planning agency as a backdrop [emphasis added] for the third-party purchasers' and providers' evaluation of the medical oriented programs reflected in hospital budgets for 1972-73 and beyond.

However, the Hospital Association notion of "positive planning" did not fit with the Blue Cross view. Indeed, HPC service in a "backdrop" capacity would not adequately meet the Blue Cross needs that had precipitated discussion of a new HPC role in the first place. Plagued by an inability to make decisions regarding certain hospital proposals, particularly a number of very expensive proposals from the state's large medical center, Rhode Island Hospital, Blue Cross pushed for a stronger HPC role, one that would include not only the formulation of a meaningful

plan but HPC review of specific hospital proposals as well. Blue Cross called for the development of a medically oriented review process and argued that HPC and the liaison subcommittee should temporarily suspend work on long-range goals and objectives, concentrating instead on implementation of a review process that would be of immediate assistance to Blue Cross in its budget negotiations with the hospitals. Initial hospital resistance to such a new planning role was countered by a strong stand from Blue Cross. As one Health Planning Council member put it, "Blue Cross virtually made it a condition that HARI (Hospital Association of Rhode Island) accede to the new arrangement." Indeed, by placing a freeze on all new medical programs pending the development of a review mechanism, Blue Cross did, in fact, make hospital acceptance of the medical program review process a condition of reimbursement.

Despite their objections to some aspects of the medical program review concept, the hospitals soon adopted a more cooperative attitude. As the HPC Executive Director put it, "The hospitals were willing to accept a new age, with some assurances that it would be administered fairly." Indeed, most of the parties engaged in these early deliberations viewed hospital association participation as crucial to its development and continued operation. One HARI official put it this way: "We were able to play a positive role because, rather than being its victims, we were now participants in the design of the process." Just as in the budget decisions themselves, negotiations and communication were important factors in the development of the medical program review process.

Other factors contributed to hospital cooperation in the formulation of a new planning role. For one thing, the notion of planning itself was one that the hospitals could embrace. As one on-the-scene observer put it: "Hospitals identify with the planning concept, promoting it as an integral part of their management operations. . . . They may reject and object to individual planning decisions, but not to the theory itself."

Perhaps more importantly, hospitals had reasons of their own to accept the planning role in general and the medical program review

process in particular. An active and involved planning organization reinforces the positions of hospital administrators who are being continually pressured by their own medical staffs' proposals for new and expanded services. Many administrators would like to oppose unwise expansion plans since they are left holding the bag if underutilized services eventually result in rising costs and deficits that they must explain to their trustees and to the public. The HPC Executive Director recognizes this function explicitly: "Once established, HPC plays a useful role as a foil to hospital administrators who must deal with their own medical staffs." The existence of a hierarchy of scapegoats aids hospital administrators by allowing them to relay medical staff proposals to to the Health Planning Council. In effect, HPC was to make the decisions regarding medical staff programs that hospital administrators, for internal political reasons, were unable to make.

During the Liaison Committee deliberations on HPC's role, agreement was reached on a method of funding the planning council's new activity. It was estimated that HPC would need two additional professional staff and one additional clerical staff person in its first year (1972-73). First- and second-year costs were expected to increase the Council's annual budget by $60,000 over the existing budget of $50,000. Since then, HPC staffing has not increased beyond these levels. HPC's funding mechanism was formally established by the Liaison Committee. The Council was to raise as much money as possible in the community, while the balance (approximately 50 percent) would be contributed in equal shares by Blue Cross and the hospitals. The Hospital Association of Rhode Island would assign each individual hospital its portion of the association's share in accord with a formula based on American Hospital Association guidelines. The HPC funding scheme has operated successfully in this manner since 1972. Recently, however, two hospitals adversely affected by HPC reviews have declined to participate in HPC funding, withholding their funding commitments to HPC in 1976.

The HPC Program Review Process

In response to Blue Cross's need for immediate assistance in dealing with hospital proposals for new and expanded programs, the development of the review process was made the first order of business; later after agreement on the new review process had been reached, the earlier work to develop a statement of goals and objectives and a listing of program priorities was resumed.

The Review process was designed in 1972-73 by a special HPC created Committee on Medically Related Program Review whose membership came from HPC itself (3), hospitals (3), and Blue Cross (3). Later, a representative of the State Budget Office was added. The requirement that hospitals must submit programs for HPC review depends on the program's projected annualized costs (including salaries, wages, supplies, depreciation and interest) in relation to the total hospital budget. The following formula is used:

	Hospital Budget	Annualized Program Cost*
Group I	$15 million and above	$100,000
Group II	$10 to 15 million	75,000
Group III	$5 to 10 million	50,000
Group IV	$5 million or below	25,000

For medical program applicants the Hospital Association of Rhode Island (HARI) has the option of conducting a peer review.

The timetable for HPC review is geared to that of the Budget Review process. The goal is for HPC to submit its advisories to hospitals and to the Budget Review Committee by the spring preceding the budget negotiations, which begin in July. By February 18th, hospitals are to inform HPC of the number and kinds of proposed new or expanded medically

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* Non-medically related programs, such as modernization of a hospital's food service, are subject to direct negotiation between the hospitals and the Budget Review Committee, with no HPC involvement.

related programs they plan to propose for the coming year. By March 3rd, hospitals are to forward detailed descriptions of all such programs. The actual HPC program reviews are then conducted by the Council's Project Advisory Committee. It assigns priority rankings and furnishes written advisories of its decisions to Blue Cross and to individual hospitals by May 1st.

In fact, this schedule is often delayed. This is most often because the hospitals fail to meet the deadlines indicated in the guidelines. "Usually we just don't get sufficient information on time," the HPC Executive Director stated.

Requests for reconsideration of HPC reviews are made to a screening committee composed of the Chairman of the Project Advisory Committee and the President and Executive Director of HPC. Proposals are not to be reconsidered more than once. On occasion, HPC's Executive Committee has reversed its Project Advisory Committee decisions. When such disagreements surface, additional pressures are placed on the Executive Director. In such cases, he must maintain a delicate balance, preserving a working relationship with the Executive Committee, while pursuing the goals indicated for health planning in Rhode Island, As one observer from the State Department of Health remarked: "It happens less often, but HPC is subject to pressure just as we are."

The State's chief negotiator and the Blue Cross Senior Vice President most involved in budget negotiations sit on HPC's Project Advisory Committee. Hospitals argue that this places them in double jeopardy: "The rate setters get a double shot at us." One HARI official interpreted the significance of that arrangement in terms of this study: "You're interested in the connections between planning and rate setting," he said, "Well, the connections can be pretty strong when the two are the same people." Blue Cross and the Budget office have responded to the HARI criticism in strong terms. In a recent letter to HARI the chief budget officer made the case this way: "Quite frankly I find it difficult to understand how the HARI Executive Committee can object to a process which included only two third-party representatives out of a fifteen-member committee, particularly

when seven of the other members represented hospital interests either directly or indirectly. Obviously, if last year's PAC was stacked in favor of any particular group, it was stacked in favor of hospitals and not third parties. Under such circumstances, I find it incredible that the HARI Executive Committee could deem the process unjust to hospitals."

Priority Ratings

As mentioned earlier, the HPC program review assigns priority ratings to each proposal, and these are used as the basis for the resultant advisories. There are three categories, of which only Priority I programs are encouraged for immediate implementation.

HPC and its Committee on Medically Related Program Review have identified several general characteristics of Priority I programs. Priority I placeas a special emphasis on the development of a coordinated network of hospital-based services. "Hospital programs which demonstrate characteristics of Priority Group I and which would arrange for the provision of needed services through the cooperative arrangements with other facilities will be given priority preference over similar individual hospital programs which the Project Advisory Committee believes could be developed on such cooperative basis."

In addition, programs offering alternatives to the basic inpatient acute care services, such as ambulatory, extended, long-term and home care are generally accorded Priority I status. Programs and services related to the development of Brown University Medical School or that have a strong community service component are often granted Priority I ratings.

With the exception of the special emphasis on cooperative programs, priority characteristics are clear but general. They allow for interpretation and negotiation and are not written in quantitative terms, such as the Hill-Burton beds-per-population ratios. Yet, the direction provided to Blue Cross and the Budget Office in the rate setting negotiations is

quite specific. Since 1975, the HPC had been subprioritizing the programs within the Priority I category and ranking them by number. In general, Priority I programs have almost always been accepted by the Budget Review Committee for inclusion in a hospital's budget.

Priority II-rated programs are not encouraged for immediate implementation or expansion. The guidelines state that: "Programs receiving a Priority II ranking have at least conceptual value but cannot be recommended for reimbursement this fiscal year. . . ." Priority II includes those programs consistent with Priority I but which require better planning or supportive data, those which are linked to "less desirable" programs, those which do not demonstrate the ability to secure needed capital or operating funds, or those which could be more effectively pursued on a cooperative basis. Programs that cannot demonstrate sufficient community impact relative to their cost are also included in Priority II.

Although HARI stresses the point that Priority II programs could, at least in theory, receive budget approval, in fact they have not been approved in the budget negotiations. Moreover, while it is thoroughly consistent with a Priority II ranking that programs be re-submitted in the next fiscal year, in fact programs accorded Priority II status are almost never re-submitted. Some observers, including the Executive Directors of the HPC and the Hospital Association, feel that a re-submission rate of only about 5 percent for Priority II programs points up HPC's previously discussed role as a "foil" enabling hospital administrators to effectively disarm medical staffs in their arguments for new and expanded services. As the HPC Director remarked, "We almost never see Priority II's back again the next year.

Programs assigned a Priority III rating are not endorsed for implementation of expansion. Priority II programs "are those which are not considered to be in the community's interest." Such programs may, for example, duplicate existing programs, fail to identify a service population or a projected community impact, or fail to demonstrate a commitment to improving utilization of low-occupancy services. More

generally, Priority III programs may be judged to be inconsistent with "general principles or goals of long- or short-range planning," or hospital goals activated in hospital plans submitted to the Department of Health.

Examination of the record from 1972 through 1974 indicates that, of program applications totalling $8,981,817, no Priority III rankings were assigned. Because of the existence of the program review procedure and the articulation of HPC goals and objectives, most observers feel, hospitals simply do not submit programs that would merit a Priority III ranking. "It should be noted that HPC has not yet had to assign a Priority III. We think that this says something positive about the hospitals' adjustment to the process," observes the HPC Executive Director.

Program Review Data

HPC program review, the basic link between planning and rate setting in Rhode Island, is guided by information gathered on an HPC "Program Description" questionnaire, here shown as Exhibit 1. As we see, the form contains eleven basic items. It asks, for example, that the applicant demonstrate community need, indicate project impact on mortality and morbidity rates, service population size, and identify possible consequences of not implementing or expanding the program. The applicant is required to justify the program with regard to similar services offered at other health facilities. Cost increases in other service areas resulting from the proposed program must be estimated. The applicant must also indicate the program's expected annualized costs for salaries and wages (identifying numbers and types of personnel needed), supplies and expenses, and depreciation and interest for the last two years, and must specify the expected contributions of third-party payers to these total costs. If capital investment is required for the program, the amount and expected sources of support must be shown. As Exhibit 1 shows, some questions require responses in quantitative terms, some clearly do not, and others are ambiguous as to the nature of the response required.

Exhibit 1: HPC Program Review Questionnaire

PROGRAM DESCRIPTION

In describing each new or expanded medically oriented program meeting the criteria for HPC review, state its specific relationship to the hospital's goals, objectives, and consequent priorities for development described in your most recent long-range plan. Indicate the specific needs which require the proposal's development at this time and the rationale as to why the particular program proposed, rather than other possible alternatives, would best meet those needs. Please follow the format suggested below in describing each program:

1. Is the program a new or expanded one?

2. If a new program, describe in terms of the following questions. If an expanded one, describe to the extent feasible both the expansion and the basic program to which it would be added in terms of the following questions:

   a. What specific hospital objective stated in your long-range plan would it meet?

   b. what demonstrated community need would it meet? For instance:

      1. Which mortality or morbidity rates would the program be expected to reduce and to what extent?

      2. How many people are expected to benefit from this program?

      3. What has been the hospital's experience in the last two years regarding the scope of this need and the effect of its actions in response to it.

   c. What institutional service needs would it meet i.e., professional, technical, educational, clinical, or other?

   d. What would be the result of not implementing or expanding the program at this time?

3. What relationship does the program have to other programs in your hospital, other hospitals or health facilities, or health agencies?

4. What alternative means of meeting the objective of this program were explored? Why did they prove less desirable than the alternative selected?

Source: Health Planning Council, Inc.

Exhibit 1 continued

5. Why should this program be implemented now as opposed to some future date? Respond in terms of your hospital's objectives and consequent priorities as developed in its long-range plan or in terms of influences outside the hospital if any are applicable.

6. What is the minimum scope of service required to make this program an effective one? What do you think would be the maximum limit?

7. What would the program's expected annualized costs be for salaries and wages (identify numbers and types of personnel need), supplies and expense, and depreciation and interest for the first two years after its implementation.

8. What other areas of service would be likely to require development as a result of implementation of this proposal? What consequent costs might be expected?

9. To what extent of total cost is each (specified) third part expected to participate in cost reimbursement?

10. If capital investment is required for the program, what is the amount necessary and what are the expected sources of such support?

11. How and when does the hospital propose to evaluate the effectiveness of this program?

Please enclose a copy of the long-range plan you submitted to the Department of Health for October 10, 1974, if you have not already forwarded one to HPC.

A copy of the hospital's long-range plan, submitted annually to the Department of Health, must accompany the program application information. The application must justify the proposal in terms of the hospital's long- and short - range intentions stated in the plan, specifying the particular plan objectives that would be met by the program. Finally, the hospital must justify the need for immediate implementation in terms of the objectives and priorities indicated in its plan and is asked to describe how it intends to evaluate the results of the program.

HPC's Executive Director stresses that this kind of information relating program proposals to long-range hospital intentions is absolutely critical. He made the point clearly: "The data gathered on the questionnaire are important, but what is really needed, and what our reviews are based on, is an understanding of the hospital's policy posture." He offered an application for a Joint Pediatrics Residency Program as an example. "The University and seven hospitals wanted to participate, so HPC got seven individual proposals with each hospital claiming that Brown would select it as a participant in the program. But Brown was vague, its hidden agenda was unclear. We required that the hospitals come back with a joint plan, and by that time the proposal included four rather than seven hospitals. Brown's plans for the affiliated hospitals are an important problem, and we are awaiting the development of a sound long-range plan that will give us the policy understanding we need." When the questionnaire responses do not supply a satisfactory explanation of the program in the context of the hospital's long-range intentions, HPC staff members utilize informal channels to secure the information. Thus, relations with individual hospitals and hospital credibility over time become an important part of the review process.

HPC supplies review decisions to the participants in the budget negotiations. They do not supply the review data itself, nor do they supply additional data or information to the rate-setting negotiations. Hospital budgets are forwarded by the hospitals directly to Blue Cross. Thus, the program review decisions themselves, Blue Cross staff members argue, are

the most significant aspect of HPC's contribution.

> The data we get from HPC and from the hospitals is of marginal value in terms of highlighting programs or allowing us to safeguard the public interest. We have no quantitative measure of program experience over time. Hospital comptrollers and managers are not geared to highlight programs. We know how many dollars they plan to spend, and how many they actually spend, but we don't get an accurate picture of the services provided, of program impact. In one instance we agreed to reimburse for a cardiologist, when the cardiologist wasn't hired, we got our money back . . .but cases are seldom that clear cut. HPC's real impact on the negotiations is in providing criteria on which to make decisions and in providing reviews that reinforce our bargaining position with the hospitals." [Emphasis added.]

HPC plays no formal role in the budget negotiations themselves."This is proper," says the HPC Executive Director,"Blue Cross, the hospitals and the state don't want others in the negotiating process. If we came in, the Consumers Council, the Department of Health, the Department of Mental Health, Rehabilitation, and Hospitals would all have a claim."

HPC's Goals, Objectives and Activity Categories

The hospital data and policy statements supplied on the program application questionnaire provide program descriptions that are measured against the need categories that HPC Committees have previously ordered in their Priority Groups I, II and III, simplifying the decision-making involved in assigning priority ranking to the program proposal. The priority categories themselves are derived from agreed on objectives for specific activity categories. The 17 page statement, Goals and Objectives for Health Services in Rhode Island, provides the planning "backdrop" originally requested by Blue Cross and the Hospital Association Liaison Committee, and is thus the basic health planning document informing the new program decisions aspects of budget negotiations.

The HPC "goals and objectives" statement is not a formal state plan,

like those developed by the Departments of Health and Mental Health, although the HPC "goals and objectives" are integrated into the Department of Health state plan. It is a document designed to inform the medical program review process. Taken together, the HPC statement and the review process itself constitute a system that highlights both the general and the specific, moving from goals and objectives in activity categories to the specific programs that establish, improve, or advance the levels of service provided in an activity category. The statement of goals and objectives was prepared by the Committee on Medically Related Program Review and thus, like so much of the rate setting system in Rhode Island, is the product of formal and informal negotiation and consensus building.

The committee "plan" defines goals in four areas: Organization; Financing; Services; and Manpower. A set of objectives are identified for each goal area (see Chart 3). The four goals and their objectives, in turn, relate to a "broad goal" for the State's health system as a whole, i.e., specificity is attained by defining the objectives for each area in particular categories of activity. For example, under the Services goal, objectives are defined for medical services, home care, obstetrics, mental health, etc.

The goals statement goes on to project phased steps for attaining the stated objectives. For example, under the Financial Goal, Objective 5 reads as follows:

> Determination of total state limits on allowable program and capital cost expansion by agreement among the network, the Department of Health, third party payers, the Health Planning Council, the Department of Administration, and appropriate legislative bodies.

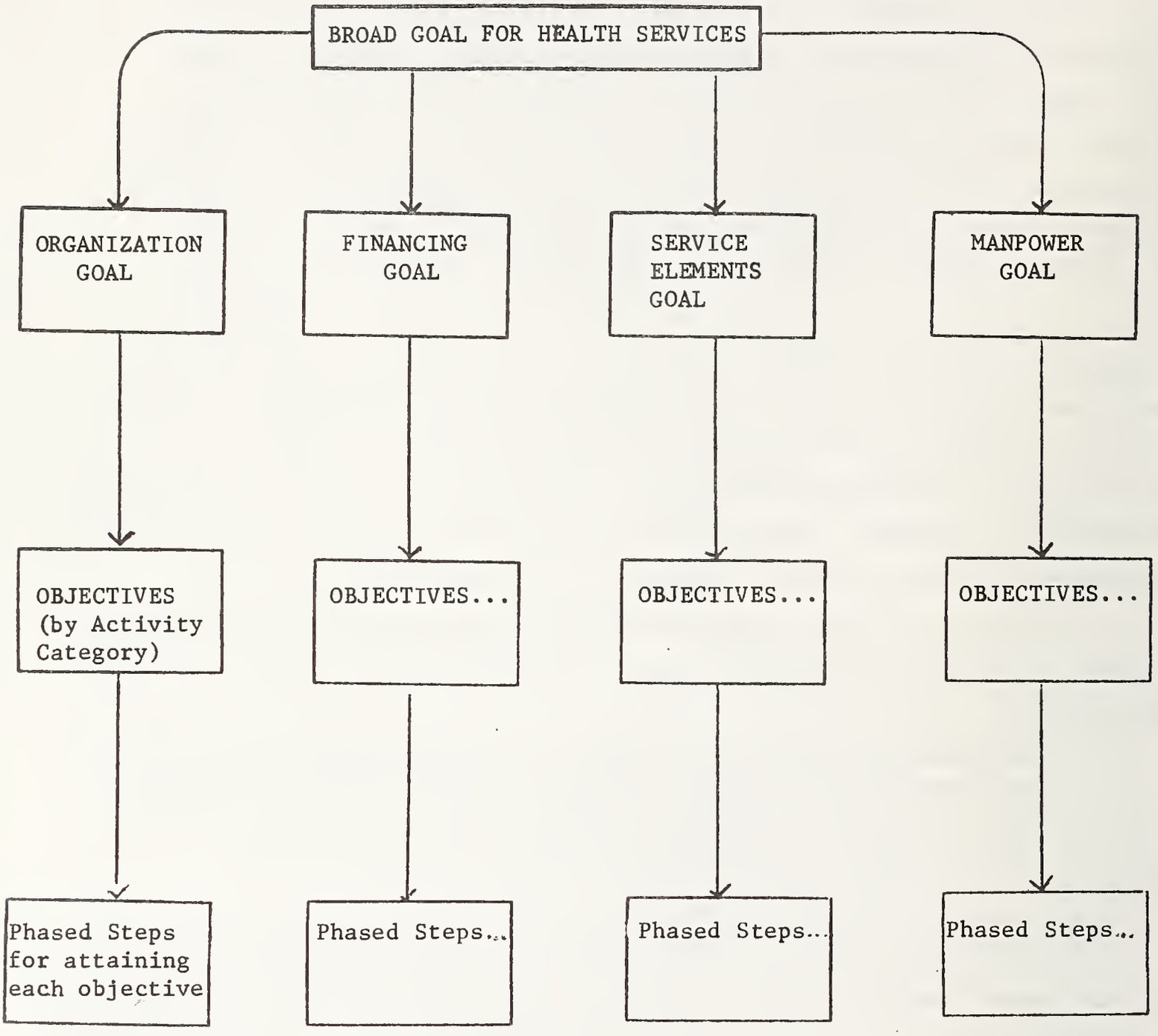
Examples of phased steps for attaining this objective are:

a) Formation of an HPC committee charged with full development of goals and objectives within three months following endorsement by the Blue Cross-Hospital Liaison Committee of approaches for positive planning...

b) Agreement by the committee, within one year of its formation, on considerations applicable to determination of total limits on allowable expansion and setting of such limits...

c) Application of agreed-up limits in budget negotiations for the following fiscal year.

Chart 3. The Health Planning Council's Approach to Defining Goals and Objectives



The Goals and Objectives statement has yet to be formally adopted. Participants argue, however, that it assists the planning process in at least three ways. Most importantly, it serves as a source of the priority groupings that are the basis of the medical program review process, the unique connection between planning and rate setting in Rhode Island. In addition, it provides a coherent statement of goals that hospitals may use as reference before they start to consider program expansion. In this capacity, it probably is a major influence on whatever deterrent and positive (forward looking) impact the planning process in Rhode Island has. Finally, it serves as a backdrop to the budget negotiations. Although the HPC review decisions themselves are more often cited in the negotiations, reference to the Goals and Objectives statement, itself a product of at least some degree of negotiation, reinforces Blue Cross and Budget Office bargaining positions.

Recent Changes in HSC - HPC Roles and Relationships

Since the operations of the Department of Health and of the Health Services Council are the only planning activities in the State that are specifically backed by law, it is clear that connections between planning and rate setting in Rhode Island in which HPC plays such a crucial role, are not reenforced by legal supports. In recent years, the State Health Department has attempted to carve out a role that will involve it more directly in review of the programmatic aspects of hospital costs, and in the budget negotiations themselves. The Department's efforts in this regard may reflect a subtle rivalry that has existed for some time between the Health Services and the Health Planning Councils, and a general desire by the Department to expand its power.

During the late 1960's and early 1970's the relationship between the two planning councils had been ill-defined and confusing. HPC had at first tried to become a B agency under P.L. 89-749, attracted by the added influence and funding that a formal role might generate. The Health Department, however, resisted the "Partnership for Health" concept embodied in the comprehensive health planning law, and opposed HCP's

efforts. (Later, as it became clear that the federal regulations would have prevented HPC from concentrating on hospitals and from functioning as a statewide agency, it independently abandoned its former interest in qualifying.) Meanwhile, however, as we saw earlier, the Department, Blue Cross and other agencies in Rhode Island had begun to rely on HPC advisories to help in various types of decision-making. By the time the Health Services Council was organized in 1968, HPC had already established its credibility.

By using HPC to furnish advisories on certificate of need reviews, some outside observers felt that the Department has restricted HPC's capacity to expand beyond its current operations. "There has been some interest in limiting HPC's role to purely technical tasks, and in containing HPC by saddling it with all the real work," remarked one Department staff person.

The State Department of Health bases its present claim to a greater role in medical program review on provisions of Rhode Island's certificate of need law. "The Brosco Law," said one Department staff member, "directs our attention not only to bricks and mortar, but to hospital expenditure as well, including programs and services." The Department's interpretation of the law was given official status in June of 1973 when the Director of the Department issued a request that the Health Services Council advise him on hospital programs as well as construction and capital expenditures. The request was intended to expand the mandate of the Health Services Council, making it, in effect, as broad as the Director's.

The Department first involved itself in the review of medically oriented programs in 1974. At the time, the Health Services Council conducted what Department staff members termed a "parallel review." As the data in the following chart indicate, the Health Planning and Health Services Councils differed significantly in their 1974 reviews.

Chart 4. Results of 1974 Parallel Review of Hospital Program Applications

Programs	HEALTH PLANNING COUNCIL New Programs: Dollars	Percent	HEALTH SERVICES COUNCIL New Programs: Dollars	Percent
Reviewed	$3,366,771	100.	$2,283,083	100.
Priority I approvals	1,267,859	37.7	449,428	19.7
Priority II approvals	1,983,592	58.9	1,833,655	80.3
Priority III approvals	-0-	-0-	-0-	-0-
Withdrawn by hospital	115,320	3.4	-0-	-0-

The data show that the Health Service Council was far more stringent than HPC's Project Advisory Committee had been (assigning 80.3 percent Priority II's versus HPC's 58.9 percent, and differing with HPC by about a million dollars.) The Health Services Council formally advanced a philosophy that hospitals should undertake to reallocate resources going into existing programs to support new ones, rather than seeking new money. In the end, a compromise was reached on the program endorsements--each planning agency modifying its initial decisions to some extent.

According to most observers, the Health Services Council's stringent posture in the 1974 program reviews was an uncharacteristic one. "The hospitals," one Blue Cross staff member observed, "have always had an easier time in the political arena, and although the Health Planning Council has also been subject to influence, the Department and the Health Services Council are even more clearly in the political arena." Another participant offered the following comment on the 1974 program review experience: "The Health Services Council did not conduct a review as substantian as HPC's. In fact, they conducted the most superficial review possible."

In 1974, the State Department of Health was attempting to establish a legitimate role for itself in the program review process. By 1975, the Department's intentions and the nature of its future participation had been clarified considerably. Despite whatever friction had existed between the two agencies, as the Health Department staff learned about the medical program review process at first hand they seem to have gained respect for HPC's performance. As a result, the State Department's participation in the 1975 program review is designed to achieve several basic purposes: to expand the Health Department role, to reinforce the Blue Cross - Office of the Budget bargaining position, while not disrupting the established HPC medical review process.

Although the parties to the medical review process, Blue Cross, HPC, and the hospitals remain the same, the Director of Health issued a memorandum on March 10, 1975 establishing a new protocol to accompany the established system. HPC Project Advisory Committee's reviews were not to be shared with and reviewed by the Health Services Council and Health Department staff before they are forwarded to HPC's Executive Committee for final action. When the 1975 reviews were completed, in sharp contrast to the previous year, the Health Services Council had completely endorsed the findings of the HPC reviews. The HSC memorandum stated:

> The Health Services Council voted to endorse the findings and recommendations of the Health Planning Council as contained in the report to the Project Advisory Committee as they relate to both the establishment of priorities and the assignment of rank order to Priority I proposals. In so doing, the Health Services Council expressed support and commendation for the thorough and comprehensive nature of the review conducted by the Project Advisory Committee.

The Health Department went further than simply accepting the HPC reviews, however. In the memorandum endorsing the Priority I proposals, the Health Services Council argued that certain "conditions and/or stipulations and restrictions must be attendant upon such endorsement." In accordance with the 1975 protocols, the Health Services Council reviews and conditions are now submitted as formal HSC

recommendations on hospital program submissions to the parties to the prospective reimbursement negotiations. The recommendations are still not specifically backed by law (although the Department is seeking just such a legal interpretation of the certificate of need law), but nonetheless they play an interesting role in the negotiations.

The Health Services Council "conditions" are formulated through close cooperation between the Department of Health and the State Office of the Budget, which, as we have seen, is a formal participant in the budget negotiations. Thus, they serve the purposes of allowing the Department to expand its role, by speaking through the Budget Office to voice a bold philosophy emphasizing reallocation of resources rather than expansion, in the process strengthening the Budget Office - Blue Cross position in the budget deliberations. Although the "conditions" reflect the planning objectives contained in the Department's plan and in the HPC statement on goals and objectives, they are principally noteworthy for their strategic significance. In one case, for example, the Health Services Council attached the "condition" that:

> Rhode Island Hospital accompany its opening of its Ambulatory Patient Center by allowing open staff privileges for minor and short-term surgery, and that the Center monitor utilization to 'insure that over time the beds displaced by the shift to ambulatory care from inpatient care are withdrawn from service.'

Buttressed by the Health Department's position, Blue Cross and the State Budget Office were able to argue successfully for a reallocation of some $400,000 and to gain the hospital's agreement to explore actively the concept of open staff privileges in their Ambulatory Patient Center operating room suites.

Blue Cross and Budget Office staff members argue that the Health Services Council "conditions" are treated purely as recommendations. In fact, it appears that whether the Health Department initiated, or Blue Cross and Budget Office initiated, the Health Services Council "conditions" are adopted in the negotiations when and to the extent that they reinforce

positions taken by Blue Cross and the Budget Office. One observer offered this summary:

> It serves the interests of the State Department in that it increases their clout. . .the Department has always been political, and in this instance it is the rate setters and not the hospitals who are recognizing that fact.

Indeed, when the Health Services Council first made its way into the program review process in 1974, taking an uncharacteristic and stringent stand, it had received substantial encouragement from both Blue Cross and the State Budget Office, who had been disatisfied with the results of the Health Planning Council's initial priority ratings.

The Future

The Health Services Council and the Health Planning Council in Rhode Island may be described as contending yet cooperating. Rivalry between the independent, voluntary planning agency and the State Department's planning and review organization was most noticeable in the early years of the Health Services Council's operation. Although, as we have seen, a new spirit of cooperation was manifested in their joint 1975 medical program review process, in recent years the Health Services Council has become more active and effective and has sought to broaden its mandate. Despite the apparent tensions that have existed (and are raised anew with P.L. 93-641), the HPC Executive Director accentuates the positive: "We like to think of the relationship as one of two parties with different functions cooperating to promote the most effective exercise of these functions. We do not feel that we contend with HSC."

With the passage of P.L. 93-641, the National Health Planning and Resources Development Act, the Health Department of Rhode Island can be expected to expand its role and its authority considerably. Section 1536 of the planning law, the Pell Amendment, would exempt Rhode Island from the requirement that it set up health planning areas within the state and from organizing Health Systems Agencies. It is expected that Rhode

Island will be the only state to qualify for the 1536 waiver. The waiver allows that no health service areas be designated for states without a county or municipal public health institution or department, and which has maintained a health planning system that complies with the intent of the law. If a waiver is approved for Rhode Island, the new State Health Planning Resources and Development Agency (SHPDA), with advice from its state-wide Health Coordinating Council, will have the authority to perform functions including those normally performed by HSA's in other states. Compliance with the provisions of the planning law will, in all probability, require a functional reorganization of the Health Department.

The future role of the Health Planning Council, which already performs a great many of the functions of a Health Systems Agency, will depend on decisions to be made by the Department's Director and the Governor. HPC may find itself functioning increasingly as staff to the Health Department, assisting in an as yet undetermined way in the certificate of need, 1122, appropriateness, and federal funds reviews that will be performed by the state agency under the law and waiver. If it continues to function in its advisory, comment and backdrop capacities, the possibility exists that, unless written arrangements to the contrary are made, the Department will have the authority to ignore HPC judgments. More importantly, the powers granded to the Department under the waiver invest it with the formal authority to preempt the innovative medical program review process that links planning and reimbursement in Rhode Island. On the other hand, it may well be that Health Planning Council credibility and expertise will enable it to preserve much of its current role. As was the case in the development of the prospective reimbursement system and the medical program review process, the other participants on the Rhode Island health scene, Blue Cross, the Budget Office and the Hospital Association will probably play a significant part in determining the scope of HPC's future role, and the nature of the connections between health planning and rate setting in Rhode Island.

SECTION III. SOME COMMON THEMES

American's "health crisis" has been diagnosed in a variety of ways. Some analysts emphasize spiralling costs. Others cite the system's apparent lack of coordination as its basic malady. Many focus on the absence of equity in the delivery of services to the nation's rural and urban poor, and their unequal ability to pay for the services they do receive. And some observers cite red tape and an intricate procedural morass as preconditions for system paralysis. Despite the uncertainty as to the relative significance of various causes and definitions of the problem, there has been some convergence on the matter of its cure. While many policy areas remain firmly in the grips of a post sixties malaise, in health, a rough course of action appears to have been chosen. The health system is moving towards greater regulation, and, by all accounts, towards a greater federal role in that regulation. To be sure, at each stage along the way, there is resistance, with each witnessing a balancing of market and regulatory solutions that is politically appropriate at that point in time.

Currently, for example, we see opposing positions embodied in the Health Maintenance Organization Act (federal assistance of an open market approach), the Professional Standards Review Organization program (a degree of self-regulation), and the National Health Planning and Resources Development Act (in its initial conception, strong federal direction of local health planning). Of the three, the new planning law looms as the most significant precurser of a national health insurance scheme. Public Law 93-641 emphasizes local planning, but it allows an often underemphasized but important role for the states as well. With the federal requirement that all states implement certificate of need laws, and that the state Health Planning and Development Agencies administer certificate of need, section 1122, and the as yet undefined "appropriateness" reviews, the states retain considerable influence in the planning and rate setting areas.

Regional Health Systems Agencies, and below them even their

sub-area councils, on the other hand, may exercise "considerable political" clout. State agencies may find it difficult to contest decisions made by HSAs that are sanctified in part by the citizen participation effort imbedded in the law. HSA boards, similarly, may encounter problems attempting to contest decisions made earlier at the sub-area level. Where bargaining between staff, providers, and consumers at the sub-HSA level has been extensive, and where sub-area representatives also sit on the HSA board, this may prove especially true.

The linking of one or more types of regulatory activity poses both technical and organizational problems. But the fundamental issues, as the Rhode Island and Maryland cases reaffirm, are organizational and political. In comments made before the 1975 New England Hospital Assembly, the Director of the Bureau of Health Planning and Development and the chief administrator of the new planning law, provided some perspective on the organizational question:

> If local community planning doesn't work, then the federal government will step in and do the planning. . .You must recognize that there is no going back, yesterday is gone forever. . .The question is not whether there will be controls, but who will administer the controls.

Current state efforts at linking planning and rate setting and at complying with the planning law will have a significant impact on the form and substance of the regulation that is still to come.

The Rhode Island and Maryland cases (which are themselves changing rapidly) are not sufficient to provide answers to the problem of linking planning and rate setting. The records from two cases can be finally only suggestive, given the impact of key individuals and indigenous state politics. Nevertheless, the two cases do allow us to identify problem areas, and possible rate setting-planning linkage models. But many of the problems encountered in efforts at connecting planning and rate setting <u>are</u> technical; they are necessary building blocks, but not sufficient conditions for a successful joining of the two activities. Before considering some of the possible political and organizational schemes for linking planning and rate regulation, a discussion of some

of these technical prerequisites will be useful.

Some Important Prerequisites

The Maryland and Rhode Island cases offer some perspective on the significance of information in linking planning and rate setting activities. First, and most obvious, data will not be shared or used unless there is a viable organizational structure relating the organizations that collect it. More importantly, even given a viable organizational arrangement, traditional types of numerical data alone are not sufficient. Planners in both Rhode Island and Maryland stressed the need for an understanding of an individual hospital's "policy posture", of its own long-term institutional objectives, and stressed the impact of hospital "credibility" or lack of it on reviews. A Rhode Island health planner put it this way: "We need to know more than cost, utilization, population and casemix data. We need to know what is coming next, and we must have some faith in what the hospitals tell us." Thus, planners and rate setters in both states emphasized need for more reliable and specific hospital long and short range plans as a supplement to the data itself and to promises invariably made through informal channels.

Equally as important, data collection is more effective when it is coordinated with the review process in a systematic manner. In Rhode Island, data collection is tied to new and expanded program review, with direct planning input into individual hospital budget negotiations. In Maryland, where the planning structure more clearly resembles that of most other states, the planning and rate setting bodies have only recently attempted to coordinate their respective data-gathering activities. Planning data in Maryland (relating only to hospital proposals entailing expenditures of $3 million or more) are shared with the independent rate setting organization in order to insure that hospitals submit the same data to the two agencies, or document the reasons for any disparities that may occur. In theory, reporting of unjustifiably discrepant data in Maryland may serve as grounds for reconsideration by the certificate

of need agency.

In addition to emphasizing the importance of the organizational framework, knowledge of hospital long-term objectives, and coordination with the review process, planners in the two states identify certain specific kinds of data-need for conducting useful reviews. Bed utilization by service and patient origin by service data are the absolute minimum required for planning. "To do an effective job, however, we need patient data by address and demographic category, and utilization by service and diagnosis. We need to improve on our use of population data, and we need the data on time," argued a Maryland health planner.

Most planners felt that planning data should be shared with rate setting, but that the level of detail in the data needed by the two agencies is not identical. A Maryland areawide planner maintained:

> We use cost data principally to establish the economic feasibility of a project. We do not require the precision of the rate setting data, and probably wouldn't have the expertise to use it if we had it. Since the rate setters are making social decisions, not just financial ones, the important thing is that they use our data, not the other way around.

Finally, many stressed the need for a continuous flow of data. Said one observer of the Maryland health scene from Johns Hopkins:

> The planning law stipulates only that the states require providers to furnish "statistical" data. Regulations must specify both the minimum types of data needed and must provide, with the National Center of Health Statistics, for coordinated mechanisms to assure the flow of data collection, controls on its quality, and conditions of access by authorized users. The state must take the lead in developing data centers so that planners can devote more energy to analysis.

The Functions of a Statewide Health Plan

The formulation of a meaningful state plan is another prerequisite for effective planning and rate setting. Consistent with the new planning law, the statewide plan should integrate the various

areawide plans that define objectives for each area. The two cases indicate that the basic criterion of an areawide or state plan should be its usefulness to the regulatory review process. As a minimum, the plan(s) should establish preset criteria for certification decisions, whenever possible in quantitative terms or specific language. It might, in addition, establish priority categories allowing the ranking of proposals in accordance with some perception of overall community need. In stating long and short range goals and objectives, the plan serves as a backdrop to rate setting and planning activities. In establishing specific categories or priorities of services, facilities, and community impact goals, it furnishes the basic instrument used in making certification reviews.

In states where planning and rate setting are conducted by separate agencies, a meaningful plan will reinforce both. It will benefit the rate setting agency by documenting and reinforcing the decisions that are implicit in their control of operating budgets, to allow for staff additions and other new costs program expansions, and interest and depreciation associated with new facilities, bond flotation, etc. To the extent that the plan is viable, it will strengthen the planning agencies by, at the same time, placing constraints on rate setting discretion, and reducing the potential for disagreement between the two agencies. When there are separate planning and rate setting organizations, rate setting participation in the development of the plan could provide a cost perspective that planners may lack, and might increase the likelihood of cooperation between planners and setters in plan implementation.

However, the mere formulation of a specific plan integrated with the review process is not substitute for an effective organizational structure backed by legal supports. As is the case with data, a plan can be used, misused, or ignored. Indeed, excessive emphasis on the development of a plan may deflect attention from more important tasks. Marris and Rein have made the point quite forcefully:

> Comprehensive planning can be worse than irrelevant, it can create problems for a government by making unfulfilled promises to groups. . .The realignment of power and policy must be achieved first, and this depends as much on new men as new ideas. No formal procedure for integrated planning can persuade independent powerful executives to abandon their prerogative.[15]

Indeed, many observers of P.L. 93-641 implementation have already noted that Health Systems Agencies (both new HSA's and established B agencies becoming HSA's) may well devote their first years of operation to plan formulations and other organizational start up activities. During this period, these HSA"s would have "conditional" status only, and would not exercise the regulatory powers granted them under the law. If HSA's choose to devote most of their resources to plan development (often emphasizing time consuming consensus building in developing plans) their regulatory activities may well suffer as a consequence.

The Review Process

The regulations governing the administration of state certificate of need laws have a significant impact on planning and rate setting through their control over what gets reviewed, when and by whom. Although P.L. 93-641 will be the chief determinant of the review structure, the Rhode Island and Maryland experiences indicate that the specific procedures followed in conducting reviews are important. Since HEW has not yet determined whether or not it will publish a model certificate of need law, and since a model law would not be binding, the states retain a significant degree of discretion in this area.

First, the determination of what gets reviewed will impact planning-rate setting relations. Although Rhode Island has a separate medical program review process conducted by a voluntary planning agency, most states do not. From the perspective of cost containment, state certificate of need reviews should include medical programs as well as new construction or expansion and Section 1122 capital expenditures. Dollar thresholds and change in bed number criteria should be sensitive

to program changes. Since rate setting agencies may be making decisions on operating budgets that are heavily affected by program changes and new interest and depreciation costs stemming from new construction and other capital expenditures, it is important that the planning function embrace changes in programs, facilities and equipment in order to prevent exclusive rate setting control, or a performance of planning functions by rate setters in a major cost area. Lack of such coordination may promote both territorial and philosophical conflict, as it has in Maryland. Review of program changes is in the interest of planning agencies, moreover, because it allows them the kind of comprehensive input into the decisions affecting the health system that they view as their duty to provide. A statewide provision ensuring coordination in the area of what gets reviewed will require planning and rate setting agencies to work together more closely, and thus possibly more cooperatively.

Secondly, state regulations may influence who is involved in the review process. In addition to the structure provided by Public Law 93-641, the state may require HSAs to furnish advisories on proposed hospital budgets to the rate setting agency. Conversely, the rate setting agency might be required to serve in an advisory capacity to health systems agencies. Such a proposal would require additional state funding of rate setting agencies to provide for increased staff, including persons acting in a liaison capacity to HSA's. While rate setting agency advisories would not be binding, discussions and negotiations of disagreements at an early point in the process will promote cooperation, while limiting the exercise of rate setting agency ex post facto veto of planning approvals that occurs in Maryland. Given the nature of the rate setting task and the levels of staffing and expertise in federally funded HSA's, reciprocal HSA review of rate setting decisions would not appear to be practical at this point in time.

Finally, timing is important as well. State regulations should be specific as to timing requirements, but they should allow sufficient time for rate setting or planning advisories. This would limit the ability of applicants, rate setters or planners to effectively stifle

input from other agencies through overloading or delay. On the other hand, planning review and rate setting advisories should be sequenced so that hospitals get a clear picture of where they stand. Hospitals should be appraised of the potential for eventual planning or rate setting veto early on, and should be encouraged to modify proposals accordingly.

Hospital Administrators

Both the Rhode Island and Maryland cases point up the need for planners and rate setters to work more closely with hospital administrators. The roles played by the Hospital Association of Rhode Island in developing the program review process, and by the Maryland Hospital Association in the establishment of the Cost Review Commission underscore the hospital view that participation in planning and regulatory processes is in their interest. Communication among rate setters, planners and hospital administrators may increase the impact of regulatory and planning agencies by making their positions and the prospects for specific proposals clear to administrators. Many health planners and rate setters in Rhode Island and Maryland have argued, in addition, that hospital administrators should be assisted by these agencies in developing the control mechanisms necessary for effective management.

Funding and Staffing

In the final analysis, the availability of dollars and people will have a major impact on the activities of both planning and rate setting agencies, and upon their capacity to interact effectively. Federal funding of Health Systems Agencies under P.L. 93-641 may not be sufficient to support the level of activity necessary for effective planning, or for planning-rate setting liaisons. In a May 1975 memo, Bureau of Health Planning and Resource Development officials warned:

> Perhaps the most serious potential problem facing implementation of the law is in the federal funding level. To the extent the President's F.Y. 1976 budget request is enacted, Health Systems Agencies will not have sufficient resources to do the job. It is possible that some CHP areawide agencies will survive with a budget at or below the level they had under CHP. If sufficient funds are not appropriated, the program is doomed to failure. Given the unique relationship between HSA's and the federal government, they must look to us for almost all their support.[16]

Rate setting agencies may face similar constraints. In Maryland, present staffing and funding of the Cost Review Commission has limited its activities, while making it vulnerable to manipulation and overburdening.

In fact, at this writing, the funding outlook for HSA's does not appear to be optimistic. Recent estimates by federal officials are that HSA's will receive funding for planning functions in the neighborhood of 20 cents per capita for their service areas. The projected figure is considerably lower than the 50 cents per capita funding indicated in the law, and would, in fact, leave many HSA's with support at levels lower than those received by B agencies under the old CHPA planning system. Indeed, should the administration's bloc grant proposal win acceptance (which is doubtful) even these projections may prove to be optimistic.

Finally, staffing of HSA's and rate setting agencies will impact their capacity to interact. Not only numbers of staff, but kind of staff are important. Experiences in Rhode Island and Maryland indicate that rate setting agencies would do well to diversify staff expertise to include not just cost consciousness, but community consciousness as well. Planning agencies, while obviously needing these skills, will have to increase staff competence in the budget and accounting areas with which rate setters primarily deal. Both agencies would increase their resources through added legal expertise and understanding of the political arena.

Structural Models

Despite the fact that, for the most part, P.L. 93-641 will determine the structural organization of the planning process within the states, the law does leave some room for variation. Since the law does not mandate the link between planning and rate setting (although it supports experiments to that effect), the states retain flexibility in relating rate setting and planning activities. A number of combinations are possible, each organizing and performing the individual functions discussed earlier (formulating a plan, organizing an information system, designing hospital review processes, etc.) in different ways. Since the prospects for implementation of Public Law 93-641 remain somewhat unclear, and since the experiences analyzed to date does not yet permit conclusions in this area, little more than an outline of the various linkage possibilities can be attempted here.

Separate Planning and Rate Setting

A separate planning and rate setting structure should include formal links between a rate setting body (either independent or within state government) and a planning body. Since P.L. 93-641 grants final authority for certificate of need, section 1122, and appropriateness reviews to the State Health Planning and Development Agency (SHPDA), the likely planning candidate would be the state agency rather than the SHCC or HSAs. To do otherwise would be to include a planning component that is incomplete, lacking many of the teeth provided under the law. Linkages at this level would alter the nature of the checks and balances that have existed between rate setting and planning agencies, combining agencies with powers sufficient to provide incentives for cooperation and communication. The effectiveness of connections between separate planning and rate setting bodies would depend upon the degree to which the two agencies fulfilled the prerequisites outlined earlier, cooperation in the review process, an information sharing mechanism, plan development, etc. The model allows for considerable variation in

organizational combinations, and serves as the basis for whatever discoverable links exist between planning and rate setting in many states today. Linkage at the state level offers the advantage of greater staffing expertise and legal authority. Formal and reciprocal advisory relationships could be the basis for this sort of combination of separate planning and rate setting agencies.

Recently in Massachusetts there has been a proposal to link planning and rate setting at the Health Systems Agency level. According to the proposal, HSA's would provide non-binding advisories to the rate setting commission on budget decisions affecting hospitals in their areas. Thus, the program would allow one-way planning input rather than a formal reciprocal working arrangement. It would offer communication, rather than linkage in a stregthened regulatory program. Although the Massachusetts scheme would not have the clout of a system linked at the state level, if HSA funding sufficient to allow such input was to be forthcoming the system would have the advantage of providing for a greater consumer voice in both planning and rate setting, in the process meeting the basic legislative goal of making regulation not only more effective, but more responsive and democratic as well.

Unified Planning and Rate Setting

The unified or public utility model has received the most attention and has attracted the largest number of proponents among planners and rate setters. The Director of the Regional Planning Council in Maryland argues:

> It makes good sense to combine planning and rate setting. Certification and rate setting are essentially planning functions, and the added jurisdiction over operating budgets would increase the impact of planning on the health systems tremendously.

Others, among them many state hospital associations, offer a theoretical objection. Cost consciousness and planning consciousness are logically distinguishable, they argue. "If planning and regulation are combined, planning will probably be submerged. The community case suffers enough

with planning input alone," argued one informed but neutral observer of the Rhode Island health scene. In fact, Connecticut, New York and Arizona came closest to this model.

As before, P.L. 93-641 would seem to dictate that the unified agency be placed within the SPDA. Separate staffs with a single decision body or closely-tied agency subunits with both staff and policy responsibilities would form the basis of such a unified system. Since other important planning functions (including HSA review of applications for federal funds) will be conducted by the HSA's and SHCC, and since a basic intention of the law is to provide for consumer input, the unified planning-rate setting agency would do well to explore further links with these organizations. Here again, HSA funding and staffing may constitute obstacles to truly effective linkages of this kind.

The combination of planning and rate setting functions at the SPDA level would buttress the existing three-piece planning structure at the state level, but, to the extent that SPDA controlled rate setting powers, it may compromise legislative intent by strengthening state governments at the expense of HSA's.

Representative Rate Setting

In a third alternative, rates could be set in negotiation between members of an independent rate setting body. Such a rate setting council might include third party payers, and delegates from the HSA's and the SPDA. Alternatively, it might include third party payers, SPDA and SHCC delegates, since the SHCC is itself composed of 60 percent HSA representatives. In addition, either individual hospitals or the Hospital Association acting on their behalf would participate in the rate setting negotiations. An added control might include the formulation of a statewide Maxi-Cap, as in Rhode Island, to set the regional limit of hospital expenditures to be allowed and thus force choices of resource allocation.

Such a system would reflect both the strengths and weaknesses of

P.L. 93-641 structure, including the much debated value of a strong consumer role. A major obstacle would be the short supply of financial expertise and its disproportionate allocation within the council. Delegates would have to serve terms long enough to support credibility and to prevent short term fluctuations in council policy. HSA or SHCC delegate selections would have to be made in a manner to prevent third party payer or SPDA domination. The approach, should it be attempted, would undoubtably require considerable experimentation and adjustment over time.

Federal Control

Direct federal control of rates and some planning functions could all come at once, or it could take the form of regulations stipulating minimum standards for certificate of need review, rate setting formulae, and other activities. But a full discussion of a federal control model is premature. P.L. 93-641 is itself a test of a system of halfway measures, and the implementation of the law, like its development in the Congress, will provide an arena for bargaining, experimentation and accommodation.

At present, the law offers an opportunity (some have said a last chance) for the states. Many of the more significant planning teeth associated with the law are vested in state agencies. These include certificate of need, Section 1122, and appropriateness reviews. Of the formal powers mandated by the law, only one important function, the review of certain federal funds coming into their areas, rest with Health Systems Agencies. And in the early implementation stages of the law, the states have moved successfully to carve out a larger role in the new system. They have, for example, achieved access through the influence of the National Governors Conference to the regulations decision-making process, secured an expanded role in the selection of Health Systems Agencies, successfully maintained a role for existing regional planning bodies and county governments as HSA's, and influenced staffing selection processes in the Federal Planning Bureau.

As the states gain a larger role in the program, however, they also acquire greater responsibility for it. By developing effective linkages between planning and rate setting to attempt to contain hospital costs, the states can pursue both the goals of the legislation and their own interests.

FOOTNOTES

1. State of Maryland, Health Services Cost Review Commission, Position Paper on Selected Problems and Issues, May 1975.

2. Lefkowitz, Bonnie, "Health Planning and Certificate of Need in Maryland," unpublished, Harvard University School of Public Health, 1975, p. 11. (Includes a summary of Maryland health profile statistics.) The Lefkowitz study provided invaluable guidance for the Maryland section of this paper, and the author has drawn heavily on it for background information and assistance in formulating interview questions.

3. Article 43, Section 559(a-1), Annotated Code of Maryland, Chapter 222, 1968 Laws of Maryland.

4. Lefkowitz, op. cit., p. 12.

5. State of Maryland, Comprehensive Health Planning Agency, Comprehensive Health Plan for the State of Maryland, Baltimore, Maryland, 1973.

6. State of Maryland, Health Services Cost Review Commission, op. cit., p. 8.

7. State of Maryland, Health Services Cost Review Commission, Guidelines for Commission Staff Rate Review, printout, July 1, 1975, p. 2240.

8. Ibid. p. 2242.

9. State of Maryland, Health Services Cost Review Commission, Report to the Governor, Fiscal Year 1975, p. 41.

10. Goulet, Gerard, "Lessons for Health Planning: The Certificate of Need Experience in Rhode Island," Dept. of Epidemiology and Public Health, Yale University, 1975 (unpublished), p. 34. Gerard Goulet's paper provided useful historical background to the Rhode Island portion of this paper.

11. State of Rhode Island, Department of Health, Plan for Health Care Facilities, 1974, p. B-1-iii.

12. Goulet, op. cit., p. 36.

13. Rhode Island, P.L. 1958, ch. 171; General Laws 1956, Sec. 23-16-12 and 23-16-13.

14. The history of the program and its process is fully described in Bauer, Katharine, and Clark, Arva, "Budget Reviews and Prospective Rate Setting for Rhode Island Hospitals," Harvard Center for Community Health and Medical Care, 1974.

15. Marris, Peter, and Rein, Martin, Dilemmas of Social Reform, Aldine Publishing Co., Chicago, 1967, p. 159.

16. United States, Department of Health, Education and Welfare, Public Health Service, Bureau of Health Planning and Resources Development, Operational Planning System, DRAFT , April 14, 1975.

APPENDIX I: THE REVIEW PROCESS IN THE BALTIMORE AREA

THE REVIEW PROCESS IN THE BALTIMORE AREA

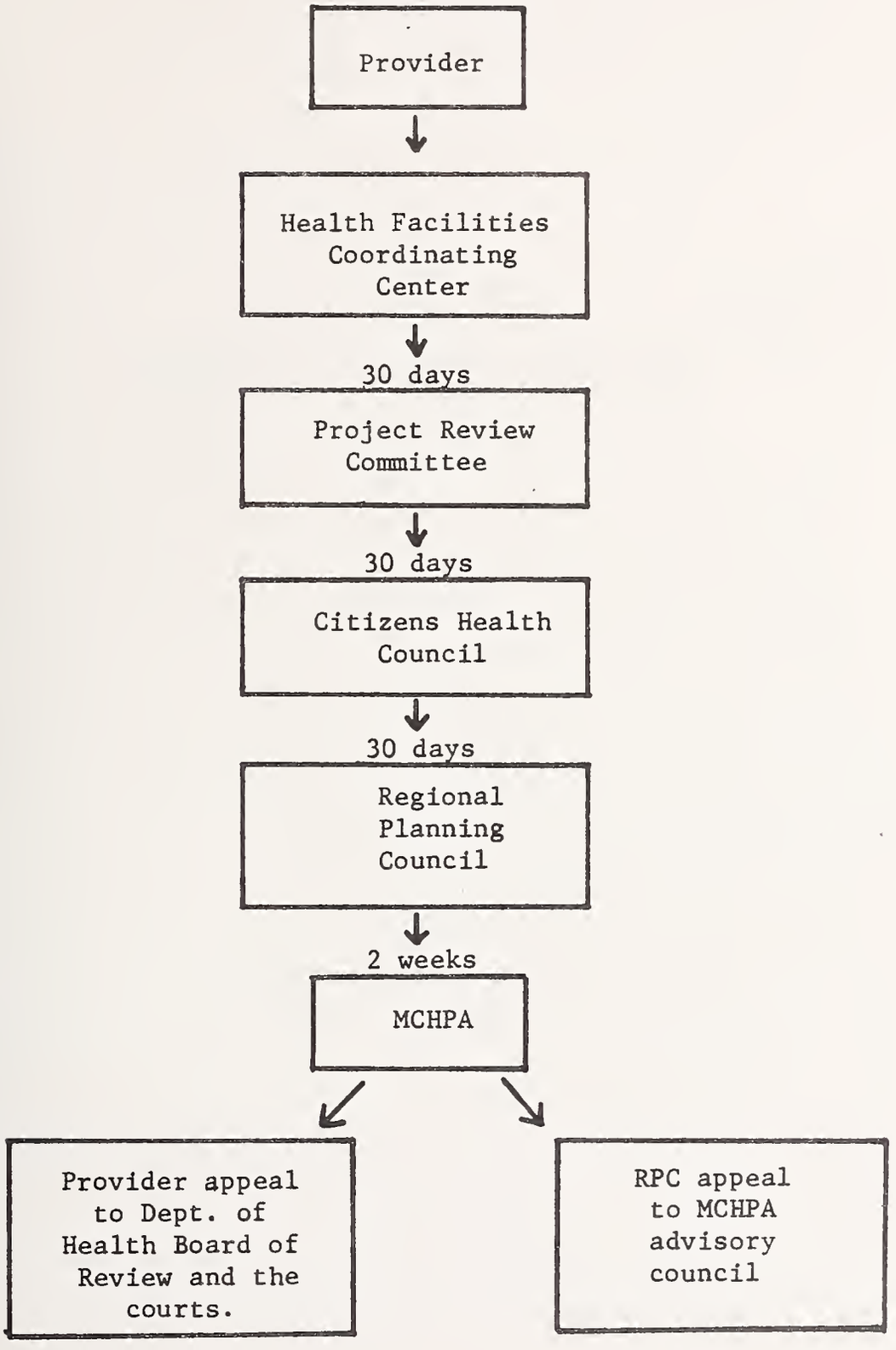
Applications for Certificate of Conformance are forwarded from the hospitals to the Health Facilities Processing center. The center, established by the MCHPA, registers the application and reviews it to see that it is technically complete. Following the technical review, the application moves to the Regional Planning Council's Project Advisory Committee. At this time, copies of the application are distributed to MCHPA and the Cost Review Commission by the center. Project review committee reviews generally take thirty days, although MCHPA grants extensions throughout the process upon demonstration of need for additional time. The next step in the process is review of the application by RPC's Citizen's Health Council. The regulations allow thirty days for CHC review. The Citizens Health Council issues an advisory to the Regional Planning Council itself, which consists of representatives of six Baltimore area county governments. After a period of up to thirty days (but usually less than two weeks), RPC forwards the final areawide recommendation to MCHPA. Within thirty days, MCHPA must endorse the areawide agency recommendation, confirm it with modifications, or require reconsideration by the "B" agency.

MCHPA, established by regulation as "The single state agency responsible under the law ... and designating the respective areawide health planning agencies to act as its agent", may intervene in the areawide review process or overturn decisions where they are "incomplete, inappropriate, or biased", or where the project "cannot be reconsidered by the areawide agency in a reasonable time." If MCHPA requires modifications, an additional joint state and areawide review is conducted. Areawide agencies may appeal MCHPA reviews to the advisory council to comprehensive health planning Executive Committee. Certification is for one year, with re-certification required yearly until a final "pre-opening" certification is issued. There is no ongoing certification mechanism.

The certification of conformance review process is summarized in the following diagram.

CERTIFICATE OF CONFORMANCE REVIEW PROCESS

FOR HOSPITALS IN THE BALTIMORE AREA



APPENDIX II: THE HOWARD COUNTY CASE

THE HOWARD COUNTY CASE*

The controversy surrounding efforts to build a general hospital in suburban Howard County began in 1971, and continues today. Three major hospitals competed for certification to build in Howard County. The first two major contestants, Bon Secours and Lutheran were hospitals from northwest Baltimore's ghetto area seeking (as many hospitals have), to relocate in the suburbs. The third major applicant, Columbia Hospital, opened a sixty bed pre-paid clinic in Howard County to serve members of its Columbia Medical Plan, but soon extended its enrollment to the community and announced expansion plans.

The first phase in the Howard County narrative is marked by the submissions to the areawide agency of competing applications. By May 1972, Bon Secours and Lutheran Hospitals, and a third group, the Hospital Corporation of America (HCA) had filed applications, describing the cost, form, location, and projected impact of their respective proposed facilities. RPC was immediately confronted with the task of developing review criteria; criteria that, in addition to guiding the review process, would assure the continuation of service to the northwest Baltimore area.

In August of 1972, RPC formally accepted the Howard County applications for joint review. RPC health planners studied bed requirements for Howard County, verifying the need for a single 115 bed hospital in addition to the existing Hopkins affiliated Columbia Medical Plan hospital. The Bon Secours application had the advantage of providing more services in the northwest Baltimore area, while Lutheran's application indicated a more substantial educational program. A Maryland Hospital Association staff person described the RPC review process this way. "Much of it hinged on the hospital's verbal commitments regarding post construction services in Howard County and the city, so hospital credibility became a major issue." On February 3, 1975, following a long period of revision in the hospital applications (conducted in negotiation with the RPC health staff) the project review committee of RPC endorsed the Lutheran Hospital proposal, rejecting the Bon Secours and HCA bids. The project review committee recommendation was affirmed by the Citizens Health Council in an approval that emphasized Lutheran's commitment to both northwest Baltimore and Howard County, and its educational program. Two weeks later, however, the Regional Planning Council overturned the CHC decision (and the seven months of reviews it represented), voting to certify Bon Secours. "There was no plan, no specific review criteria . . . RPC is a political body, and given the absence of these constraints, it responded to Bon Secours superior political influence", remarked a Hospital Association observer. Indeed, in making this reversal RPC cited as Bon Secours strengths the very items that had been considered its weaknesses in the Project Review Committee and CHC judgements.

MCHPA, wary of disrupting the review process further by overturning the RPC reversal, responded with a variety of strategies. It made an unsuccessful attempt to revoke RPC's authority by appealing to

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*This discussion is taken in part from the study by Bonnie Lefkowitz cited in footnote 2, page 80 above.

its Advisory Council, emphasizing the dangers of dominance of the CHC by a political body. Next, MCHPA remanded the decision to RPC for reconsideration, suggesting bias in the RPC deliberations, and requesting a specification of review criteria. But in response, RPC upheld its previous decision. MCHPA next attempted to organize a joint Lutheran - Bon Secours venture, but failed because of Bon Secours refusal to cooperate in an abortion referral program. MCHPA's final strategy was a public one. Faced with mounting publicity on the abortion issue, it endorsed the need for abortion referral, making Bon Secours approval conditional on their acquiescence on the abortion issue. When, as expected, Bon Secours reaffirmed its abortion stand, MCHPA disapproved its application. Despite pressure from Bon Secours constituencies, the Secretary (acting in his capacity as MCHPA chairman) upheld the MCHPA decision, in the process also certifying the Lutheran application.

Rather than appeal to the Health Department's Board of Review, Bon Secours re-evaluated its position, and opted for cooperation with Lutheran in a joint venture. At the same time, Columbia Hospital announced its decision to expand their prepaid plan in Howard County's community hospital. Given pressure from Columbia Hospital and its Howard County constituency, and recognizing that the new joint Lutheran - Bon Secours proposal for two facilities in Howard County (and two in northwest Baltimore violated the RPC verification of "need" for only one new Howard County hospital and the general RPC bed moratorium as well, the Secretary agreed to a de novo review of the entire situation. Soon after, and for a number of reasons including opposition in the Howard case, the Secretary removed the MCHPA director, replacing him with the Department Budget Director. In the meantime, the Board continued its review.

Columbia Hospital pursued a number of strategies to block the Lutheran and Lutheran - Bon Secours proposals. These included appeals to the Board of Review questioning the Secretary's power to intervene, severing their formal ties with Johns Hopkins, appealing to the Howard County courts to enforce zoning restrictions blocking the Lutheran plan, and discouraging RPC re-certification of the Lutheran proposal. Bon Secours in the meantime, pressed the interpretation that the Secretary's denial of its certification covered only the portion of its application pertaining to its general hospital proposal. It could, Bon Secours argued, continue to build a "health park" including office buildings and an ambulatory care clinic. The Bon Secours interpretation offered the Board of Review the political compromise it needed. Finally, two and a half years after the case had begun, the Board approved the Lutheran hospital, allowing Bon Secours to build its "health park." In its decision the board promised northwest Baltimore increased services, and allowed Columbia (now Howard Community General) to maintain its 60 bed facility. But still, the controversial case continued.

In the summer of 1974, Howard Community General offered to abstain from further challenges to the Lutheran plan in return for Lutheran's support of its expansion plans. Soon after, a Howard County

Government attempt to have all decisions set aside in favor of a Howard County government plan failed. Howard County General pursued its expansion plan, fighting RPC bed need statements (which had varied from 260 to 400 over the two year period), and formally submitting an expansion application. As events continued to unfold, northwest Baltimore community groups were pressing for delivery of promised increased services, asking for more doctors and black doctors in particular, and for subsidy of the Lutheran and Bon Secours inner city hospital debts and free care responsibilities by their more affluent Howard County counterparts.

The Howard County case captures in microcosm many of the characteristics of health planning in Maryland. It underscores the political nature of the planning process. In particular, it highlights the role played by a bifurcated areawide agency decision making process, and the influence of affected interest groups. It indicates that Secretarial intervention may have a decisive impact on the process and its results, particularly as regards conflicts between the state and areawide agencies. In making its decisions, moreover, the Board of Review appears to have been guided more by political consideration than by planning logic. The absence of a plan containing specific review criteria complicated areawide agency efforts to deal with competing applications. Increasingly, the areawide agency was criticized for basing its decisions on insufficient or improvised criteria. With such criticism came the introduction of additional political and social issues, increasing areawide agency vulnerability and the saliency of internal political channels. As the review process deteriorated, formal time constraints became more flexible, resulting in a process lasting almost three years. Given the constellation of contextual factors that exists in Maryland, including the personalities involved, the configuration of political and economic interests and influence in the state, a system based on an "A" agency housed in the State Health department and "B" agencies that exist as "quasi-state" organizations subject to ultimate control of the "A" agency, the key participants in the Maryland system could not manage the delicate balance between planning and participation so as to effectively pursue the general health system objectives that, in theory, they firmly supported.

Still, whatever the inadequacies of the planning process in the Howard County case, the system was not entirely without benefits. A Maryland Hospital Association put it this way: "Originally there were applications from Lutheran, Bon Secours, Columbia and the Hospital Corporation of America. There is a consensus that the Howard County experience was a traumatic one, but without it, there may well be four hospitals, rather than the two major health facilities in Howard County today."

APPENDIX III: MEMORANDUM ESTABLISHING NEW CONNECTIONS BETWEEN PLANNING AND RATE SETTING IN MARYLAND

Maryland
Comprehensive
Health Planning
Agency

HEALTH SERVICES
COST REVIEW
COMMISSION

May 27, 1975

TO: All Hospital Administrators

FROM: Harold A. Cohen, Executive Director
Health Services Cost Review Commission
Leonard E. Albert, Executive Director
Maryland Comprehensive Health Planning Agency

We wish to bring to your attention certain arrangements which we are implementing in order to best serve the industry and the public in having an orderly health planning process and reasonable charges for health care services. The Health Services Cost Review Commission and the Maryland Comprehensive Health Planning Agency have separate, but in some respects related, responsibilities. This memorandum summarizes our procedures for maintaining full communication on and coordination of the related responsibilities. We believe the procedures will assist you and us in meeting and performing our associated responsibilities in a fair and knowledgeable manner.

The Maryland Comprehensive Health Planning Agency, with the designated areawide health planning agencies, has under the State Certification of Conformance program the responsibility of determing whether new hospital facilities and services, or changes to existing facilities and services, are in conformance with the comprehensive health plan, including their need. Under the coordinated Federal Section 1122 program, it has the additional responsibility of determining whether the capital expenditures required for such projects are economically feasible, can be accommodated in the patient charge structure without unreasonable increases, and will foster cost containment or improved quality of care through efficiency and productivity.

The Health Services Cost Review Commission has the separate, but closely related responsibility of seeing that when such services or facilities are determined in conformance to the plan, rates are eventually approved which permit the applicant facility to provide these services in an effective and efficient manner on a solvent basis (in the case of a non-profit institution), or on a reasonably profitable basis (in the case of a for-profit institution).

To assure the coordination of these separate responsibilities, and also to maintain a continuity of understanding betwen the applicant, the CHP agencies, and the Cost Review Commission throughout the life of the Certification process, the Cost Review Commission will receive copies of all applications at the start of review. These will include the

applicant's financial feasibility and activity projections. As a standard practice, the Cost Review Commission will review major hospital projects, and will report its comments to the CHP agencies in a timely fashion with a copy to the applicant. These comments will be used in addition to the CHP agencies' own reviews as an important part of the Certification determination.

Further, Certified project applicants for at least major hospital projects will be required to submit simple updated financial feasibility and activity projections on a reasonable periodic basis to the CHP agencies for monitoring purposes. These will also be reviewed by the Commission, which will provide its comments to the CHP agencies with a copy to the applicant. This procedure will be followed through the life of the Certification, up to the Pre-Licensing (First Use) Certification review.

In these functions the Commission will be assisting the applicant and the CHP agencies in their Certification responsibilities. In addition, it should be understood that the financial and activity information in the monitoring reports should be consistent with the preliminary rate request information which the applicant will be required to submit to the Commission. In effect, the initial application submission and subsequent monitoring submissions will be preliminary rate setting documents as well as Certification documents. This Certification input by the Commission, however, does not remove or satisfy its obligation to approve reasonable rates for the service or facility when it is operational.

It is our desire and expectation that this procedure will enable us to maintain a full awareness of each others views and permit us to carry out the related but individual responsibilities while eliminating the mischance of placing the applicant in double jeopardy. The responsibilities of the applicant in this arrangement are equally clear.

Formerly, the hospitals in Maryland operated with approximately 80% of their costs on a pass-through basis. They were automatically paid via cost-based reimbursement formulas. Under such a system, almost any cost is recoverable. The chief exception has been the cost of providing emergency room and clinic services. A substantially smaller proportion of these services are covered by the major third party cost reimbursers and, as a result, the costs of these services may be, and are, threatening to the solvency of facilities.

With the advent of the Health Services Cost Review Commission, financial feasibility is no longer the only relevant question; fiscal responsibility (or reasonability) is now of paramount importance. The solvency of a facility is not related only to what a buyer would pay but also to what the Commission allows them to be charged - and by law the Commission must only allow reasonable costs to be recovered in rates.

In some cases, applicants may desire expressions from the Commission as to the fiscal reasonableness of its plans. This may be desired before construction contracts are signed or before revenue bonds are let. The Commission is most anxious and willing to review

plans prior to a bond flotation so that a positive statement from the Commission may be included in the prospectus. This positive statement is in the public interest in that it may improve the marketability of the bonds and may reduce the interest rate required to sell the bonds.

Prior to the opening of a new facility or the offering of a new service, the applicant must request opening rates from the Commission. The Health Services Cost Review Commission will notify Comprehensive Health Planning if an applicant submits data, especially financial and activity projection data, which differ substantially from that considered by Comprehensive Health Planning in initially determining and subsequently monitoring conformance. In some such cases, Maryland Comprehensive Health Planning Agency may reconsider its certification.

It must additionally be noted that a determination of need by Comprehensive Health Planning and a determination of rates by Health Services Cost Review Commission does not remove management's basic responsibility. It is expected that management will base its requests upon sound data. However, should the CHP agencies find a service to be needed, and should the Health Services Cost Review Commission find the facility cost to be reasonable, then if unforeseen market developments render a service not feasible, both Maryland Comprehensive Health Planning Agency and the Health Services Cost Review Commission will consider solutions which will protect the consumer and investor, including bond holder, equity. In this event, the applicants must protect themselves by prudent action. This may well include voluntarily seeking a modification to the project, or decertification.

In summation, there are clear and serious responsibilities involved for all three parties: the applicant, the CHP agencies, and the Commission. The outlined procedures identify these individual responsibilities, and their implementation is planned to provide for their being carried out in a coordinated, accountable, and beneficial manner.

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Harvard Center for Community
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Integration of information
for hospital rate setting

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